Name:_____

Primary Doctor(s)_____

_____

Practice Name:_____

Address:_____

_____

CURRENT MEDICATIONS:

_____

_____

DRUG ALLERGIES:

_____

_____

Patient's Wish List:

Read (Bible, mail, computer)	Drive	Watch TV
See faces	Needlepoint	Arts & Crafts
Prepare their own meals	Cards/Board Games	

Other: _____

Do you Wear Glasses?_____

HEALTH HISTORY: Please check the conditions that apply to you or that run in your family.

Allergies	❑Self	❑ Family	High Blood Pressure	❑Self	❑ Family
Respiratory Disease	❑Self	❑ Family	Thyroid	❑ Self	❑ Family
Cancer	❑Self	❑ Family	Dry eyes	❑ Self	❑ Family
Diabetes	❑Self	❑ Family	Floaters/spots	❑ Self	❑ Family
Drug sensitive	❑Self	❑ Family	Flashing lights	❑ Self	❑ Family
Elevated Cholesterol	❑Self	❑ Family	Retinal Detachment	❑ Self	❑ Family
Heart problem	❑Self	❑ Family	Blindness	❑ Self	❑ Family

Low Vision of Michigan

Name: _____

Date of Birth: _____/_____/_____

Address

Street: _____

City: _____

State: _____ ZIP: _____

Marital Status Single Married Divorced Widowed Domestic Partnership Other

Home Phone (_____) _____

Cell Phone (_____) _____

Email: _____

Social Security #: ___ ___ ___ / ___ ___ / ___ ___ ___ ___

Race_____ Are you Hispanic? Yes No

Mother's Maiden Name_____

Birth State _____

Low Vision of Michigan

FINANCIAL AUTHORIZATION:

I authorize and request my insurance company to pay directly to Suburban Eye Care, P.C.

I understand that my insurance carrier may pay less than the billed services and materials. I agree to be responsible for the payment of all services and materials rendered on my behalf or my dependents. Any portion not paid by the insurance company will be the patient's responsibility. A 1 ½% finance charge will be applied to any amount over 30 days.

_____ _____

Patient/ Guardian Signature **Date**

HIPAA PRIVACY POLICY:

I have received or was offered and declined a notice of Suburban Eye Care, P.C. privacy laws HIPAA.

_____ _____

Patient/ Guardian Signature **Date**

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Suburban Eye Care, P.C. for any services furnished to me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HFCA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient/ Guardian Signature **Date**