



Dear Patient:

Please fill out the enclosed paperwork and bring it to your exam along with your insurance cards. If your insurance requires a referral or authorization, please bring that with you also; just a friendly reminder that exam fees and co-pays are collected at the time of your visit. We accept cash, checks and credit cards (VISA, MasterCard and Discover).

We may use dilating drops to examine your eyes and you will be light sensitive with blurred reading vision for several hours after. To alleviate some of the brightness, please bring sunglasses with you.

**APPOINTMENT DATE IS:** \_\_\_\_\_

**TIME:** \_\_\_\_\_

We look forward to seeing you and providing your eyecare for years to come.

Yours truly,

Lawrence D. Castleman, M.D.  
Director

/mmb

<b>PATIENT NAME</b>			<b>HOME PHONE#</b> (    )		<b>ALTERNATE PHONE#</b> Work / Cell / Other (    )	
<b>E-MAIL ADDRESS</b>						
<b>ADDRESS</b>			<b>CITY</b>		<b>STATE</b> MI	<b>ZIP</b>
<b>SEX</b>	<b>AGE</b>	<b>BIRTH DATE</b>		<b>MARITAL STATUS</b> S    M    D    W		<b>SOCIAL SECURITY NUMBER</b>
<b>EMPLOYER</b>				<b>OCCUPATION</b>		
<b>SPOUSE NAME</b>			<b>BIRTHDATE</b>		<b>SPOUSE'S EMPLOYER</b>	
<b>NEXT OF KIN NAME/PHONE NUMBER</b>						
<b>MEDICAL INSURANCE</b>						
Primary		Secondary			Tertiary	
<b>VISION INSURANCE</b>						
Primary			Secondary			
<b>REFERRED BY</b>					<b>PHONE</b> (    )	
<b>ADDRESS</b>			<b>CITY</b>		<b>STATE</b> MI	<b>ZIP</b>
<b>PRIMARY CARE PHYSICIAN</b>					<b>PHONE</b> (    )	
<b>ADDRESS</b>			<b>CITY</b>		<b>STATE</b> MI	<b>ZIP</b>

**SUPPLIER/PROVIDER OR GROUP "ONE-TIME AUTHORIZATION AGREEMENT".**

Statement to permit payment of Medicare benefits to Providers/Physicians/Patient:

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

FOR MEDICARE PATIENTS:

I authorize payment to be made to Castleman Eye/Surgery Center \_\_\_\_\_

FOR ALL OTHER PATIENTS INCLUDING PT'S WITH INSURANCE SUPPLEMENTAL TO MEDICARE:

I authorize insurance payment to be made to Castleman Eye/Surgery Center \_\_\_\_\_

DATE: \_\_\_\_\_ Rev. \_\_\_\_\_ Rev. \_\_\_\_\_ Rev. \_\_\_\_\_ Rev. \_\_\_\_\_ Rev. \_\_\_\_\_ Rev. \_\_\_\_\_

Ini. \_\_\_\_\_ Ini. \_\_\_\_\_ Ini. \_\_\_\_\_ Ini. \_\_\_\_\_ Ini. \_\_\_\_\_ Ini. \_\_\_\_\_

# HEALTH HISTORY

PATIENT NAME \_\_\_\_\_

DATE: \_\_\_\_\_

- Yes No  
  Diabetes \_\_\_\_\_ # of yrs. \_\_\_\_\_  
  High Blood Pressure \_\_\_\_\_ # of yrs. \_\_\_\_\_  
  Heart Disease \_\_\_\_\_  
  Kidney Disease \_\_\_\_\_  
  Neurological Disease \_\_\_\_\_  
  Carotid Artery Disease \_\_\_\_\_  
  Stroke \_\_\_\_\_  
  Cancer \_\_\_\_\_  
  Any Nervous Disorder? \_\_\_\_\_  
  Gastrointestinal Disease-Type \_\_\_\_\_  
  Lung Disease-Type \_\_\_\_\_  
  Hepatitis \_\_\_\_\_

- Yes No  
  Arthritis (osteo/rheumatoid) \_\_\_\_\_  
  Autoimmune Disease  Lupus  HIV/Aids  Crohn's  Fibromyalgia  
  Chron. Fatigue Syn.  MS  Other \_\_\_\_\_  
  Migraines \_\_\_\_\_  
  Head or Spinal Injuries \_\_\_\_\_  
  Seizure, Convulsions, or Fainting \_\_\_\_\_  
  (Women) Are You Pregnant or Nursing? \_\_\_\_\_  
  Permanent Defect from Illness, Disease or Injury? \_\_\_\_\_  
  Do You Live Alone? \_\_\_\_\_  
  Do You Smoke? Cig./Pks. Per Day \_\_\_\_\_ Week \_\_\_\_\_  
  Do You Drink? # per Day/Week//Month \_\_\_\_\_  
 Other: \_\_\_\_\_

Your Medical Doctor \_\_\_\_\_

Doctor's Telephone # \_\_\_\_\_

**Please List All Medications You Are Currently Taking:**

\*(The Rest of Medications may be listed on back of sheet)

**(Eye Medications)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please List All Medications You Are **Allergic** To:

\_\_\_\_\_

**YOUR OCULAR HISTORY** (Have **you** been diagnosed with any of the following in the past?)

- |   |   |
|---|---|
| Yes No  | Yes No  |
| <input type="checkbox"/> <input type="checkbox"/> Cataracts _____       | <input type="checkbox"/> <input type="checkbox"/> Crossed Eyes/"Lazy" Eye _____ |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma _____        | <input type="checkbox"/> <input type="checkbox"/> Iritis _____                  |
| <input type="checkbox"/> <input type="checkbox"/> Retinal Disease _____ | <input type="checkbox"/> <input type="checkbox"/> Corneal Disease _____         |
| <input type="checkbox"/> <input type="checkbox"/> Injury _____          | <input type="checkbox"/> <input type="checkbox"/> Other Eye Disorders: _____    |

**FAMILY HISTORY** (Has anyone in your family (**blood relative**) had any of the following?)

**NOTE RELATION TO PATIENT:** F-Father M-Mother S-Sister B-Brother GF-Grandfather GM-Grandmother U-Uncle A-Aunt

- |   |   |   |  |
|---|---|---|--|
| Yes No  | Yes No  | Yes No  | Yes No   |
| <input type="checkbox"/> <input type="checkbox"/> Glaucoma _____  | <input type="checkbox"/> <input type="checkbox"/> Macular Degen. _____  | <input type="checkbox"/> <input type="checkbox"/> Retinal Detach. _____ | <input type="checkbox"/> <input type="checkbox"/> Other Eye Problems _____   |
| <input type="checkbox"/> <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> <input type="checkbox"/> Corneal Disease _____ | <input type="checkbox"/> <input type="checkbox"/> Diabetes _____        | <input type="checkbox"/> <input type="checkbox"/> Diabetic Retinopathy _____ |

**YOUR SURGICAL HISTORY** (Please include date and type)

**\*(Surgical History may be continued on back of sheet)**

\_\_\_\_\_  
 \_\_\_\_\_

**DO NOT WRITE IN THIS SPACE**

Cataract Surgery (Date of Surgery) Right Eye \_\_\_\_\_ YAG \_\_\_\_\_ Left Eye \_\_\_\_\_ YAG \_\_\_\_\_  
 Other Eye Surgery and/or Laser (Date of Surgery) Right Eye \_\_\_\_\_ Left Eye \_\_\_\_\_

Date Reviewed \_\_\_\_\_ Tech Initial (Please Print) \_\_\_\_\_

Date Updated - Tech Initial \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

## HEALTH HISTORY

\*List of Medications (Cont'd)


\*Surgical History (Cont'd)


ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing here, I acknowledge that I have received a copy of the Castleman Eye Center's Notice of Privacy Practices.

**Patient Signature**\_\_\_\_\_ **Date**\_\_\_\_\_

DOCUMENTATION OF FAILURE TO OBTAIN SIGNATURE ABOVE

(To be completed by a Castleman Eye Center employee when indicated.)

On \_\_\_\_\_ (date), \_\_\_\_\_  
(patient's name) refused to provide their signature above when requested.

Witness (employee)\_\_\_\_\_ Date\_\_\_\_\_

CONSENT FOR USE & DISCLOSURE OF YOUR MEDICAL INFORMATION

Our purpose in asking you to sign this is to document that we have informed you that this office may use and disclose all of your medical information in our possession.

The uses and disclosures by the Castleman Eye Center of your medical information are necessary and will be used for your treatment, obtaining payment for treatment and services that we provide to you, and for health care operations. For a more complete description of how this office may use or disclose your medical information, please carefully review the Notice of Privacy Practices that we gave you today.

You have the right to review our Notice of Privacy Practices prior to signing this consent. You should carefully review the Notice of Privacy Practices because it contains a list of rights that are available to you with respect to our use and disclosure of your medical information.

By signing below, you acknowledge that you have read and understand this consent for use and disclosure of your protected medical information.

**Patient Signature**\_\_\_\_\_ **Date**\_\_\_\_\_