



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

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

For office use only:

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- Type _____ Date _____
 Anxiety disorder or depression? _____
 Gastrointestinal Disease-Type _____
 Lung Disease-Type _____
 Thyroid disease _____

- 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: _____

Please List ALL MEDICATIONS You Are Currently Taking: Continued on back of sheet

EYE MEDICATIONS

Please List All Medications You Are **ALLERGIC** To: NO KNOWN ALLERGIES

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

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

YOUR SURGICAL HISTORY (Please include date and type)

Continued on back of sheet

DO NOT WRITE IN THIS SPACE

No Ocular LASER/surgery

Cataract Surgery (Date of Surgery) Right Eye _____ YAG caps _____ Left Eye _____ YAG caps _____

Other Eye Surgery and/or Laser (Date of Surgery) Right Eye _____ Left Eye _____

Date Reviewed _____ Tech Initial (Please Print) _____ / _____ / _____

Date Updated - Tech Initial _____ / _____ / _____ / _____ / _____ / _____ U:forms

HEALTH HISTORY

REVIEW OF SYSTEMS: Do you have any of the following symptoms now?

If NO, Please check box. If YES, please circle all words that apply.

- NO **General:** fever, chills, unexplained weight loss/gain, night sweat, scalp tenderness, fatigue
- NO **Ears, Nose, Throat:** ear pain, facial pain, chronic cough, dry mouth, sneezing, hearing loss
- NO **Eye:** pain, blurred vision, double vision, redness, burning, itching, discharge, light sensitivity, flashing lights, floaters
- NO **Heart:** chest pain, rapid heart beat, high blood pressure
- NO **Respiratory:** shortness of breath, difficulty breathing, discolored sputum, wheezing, congestion
- NO **Digestive:** constipation, nausea, vomiting, blood in stools, black tarry stools, diarrhea, upset stomach
- NO **Genital, Kidney:** increased urinary frequency, pain with urination, impotence
- NO **Muscle:** pain in joints, pain in muscles, stiffness, swelling, cramps
- NO **Skin:** rash, bruising, pimples, warts, growths, redness, itching, hives, swelling
- NO **Neuro:** dizziness, weakness, numbness, tingling, trouble speaking, bowel/bladder dysfunction, loss of balance, headache
- NO **Psychiatric:** Anxiety, depression, insomnia

If you answered yes to any of the above questions and are not currently receiving care for these symptoms, report them to your family physician as soon as possible.

When did you have your last complete physical exam?

Approximate Date: _____ Family Doctor's name: _____

List of Medications (Cont'd)

*Surgical History (Cont'd)

HEALTH HISTORY

U:CEC:FORMS:healthhistory

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** _____

CASTLEMAN EYE CENTER PATIENT FINANCIAL POLICY

Thank you for choosing Castleman Eye Center. We are committed to providing you with excellent service in every area including billing and insurance claims filing. Please read and sign our Financial Policy below:

Our practice participates in many Vision and Medical insurance plans. If your plan does not cover services provided by our physicians, payment in full is expected at the time of your visit. We accept cash, checks, VISA, MasterCard, and Discover. **Please be sure to provide us with your most current insurance card(s) at each visit.**

We cannot properly file your insurance claim if we do not have accurate insurance information in your account. If you do not have your insurance card with you we will be happy to see you but payment in full will be due at the time of service. You must bring your insurance card to us in order for the claim to be filed. Once payment has been received from the insurance company, we will gladly refund the patient payment less any applicable co-pays or deductibles.

Many insurance plans are no longer using the social security number as the patient ID, and have changed to using the Employee ID as the subscriber number. If you are not the primary card holder please make sure you give us the correct subscriber (employee) ID number at the time of your visit.

Currently all of the insurance plans we are contracted with require that we provide the patient's full name, date of birth, social security number, and complete home address. If you are uncomfortable providing us with this information, we will provide you with a bill so you can file your own claim with your insurance plan. If you choose to file the claim yourself, payment in full will be due at the time of service.

All payments are required at the time services are rendered. If, for some reason you are not prepared and need us to bill you, there is an additional \$10 billing fee. We do offer financing through Care Credit and accept VISA, Mastercard, American Express and Discover.

Eye Examinations have two portions, the eye exam and the refraction. The refraction is the measurement taken to determine if there is a need for glasses and if so, your glasses prescription. Refractions may be done for routine eye exams or medical exams. **Most insurance plans, including Medicare do not pay for refractions. You will be asked to pay for the refraction at the time of your visit.**

Many insurance plans require a referral/authorization for office visits. You will need to obtain this referral/authorization from your primary care physician **prior** to being seen in our office.

If you are having surgery we will assist in getting pre-certification or prior approval for your procedure. Please keep in mind that most insurance plans have deductibles, co-payments, or both, associated with surgery, and you will be responsible for payment of these fees. We suggest that you **review your insurance plan** prior to visiting our office, so you will be familiar with your insurance plan guidelines and requirements.

Thank you, and let us know if we can be of further assistance.

I certify that the information given by me in applying for payment under my insurance contract is correct. **I authorize any holder of my personal information, whether medical or otherwise, to release to any third party payers (including Medicare, Medicaid, and other parties) information needed to process claims for health care benefits.** I request that payment of authorized health care benefits be paid and I assign the benefits payable for physician services to the physician or organization furnishing the services. I authorize such physician or organization to submit a claim to my health insurance carrier or any other third party payer including Medicare and Medicaid on my behalf. I request payment of benefits under Title XVIII (Medicare) and XIX (Medicaid) of the Social Security Act, to **Castleman Eye Center**. I understand that I am financially responsible for charges not covered by the insurance company, and I hereby guarantee timely payment in full of any such charges.

By signing below, you are acknowledging that you have read and fully understand our Financial Policy.

Patient Signature (or Legal Guardian): _____ **Date:** _____