



“Come see the people of Vision.”

Dear _____,

Welcome to our practice. I hope your visit is a comfortable one.

Your appointment has been scheduled for _____.
If you need to change this appointment, please call the office at the number below. You will be in the office approximately 30 minutes to 2 hours depending on whether you are dilated.

If you wear contact lenses, they can change the shape of your cornea and should be discontinued prior to your full LASIK evaluation. Please follow the recommendations of your optometrist or our office for discontinuing wear of your contacts. If you have not discussed this issue yet or have concerns, please contact our office. Also, you CANNOT be pregnant or nursing within the last 3 months.

Enclosed, you will find patient registration forms and a health history form. Please fill these out before the day of your visit. You may either mail them or bring them the day of your appointment.

We have included a map to make it more convenient for you to find our office. If you have any questions or concerns before your appointment, please feel free to contact us.

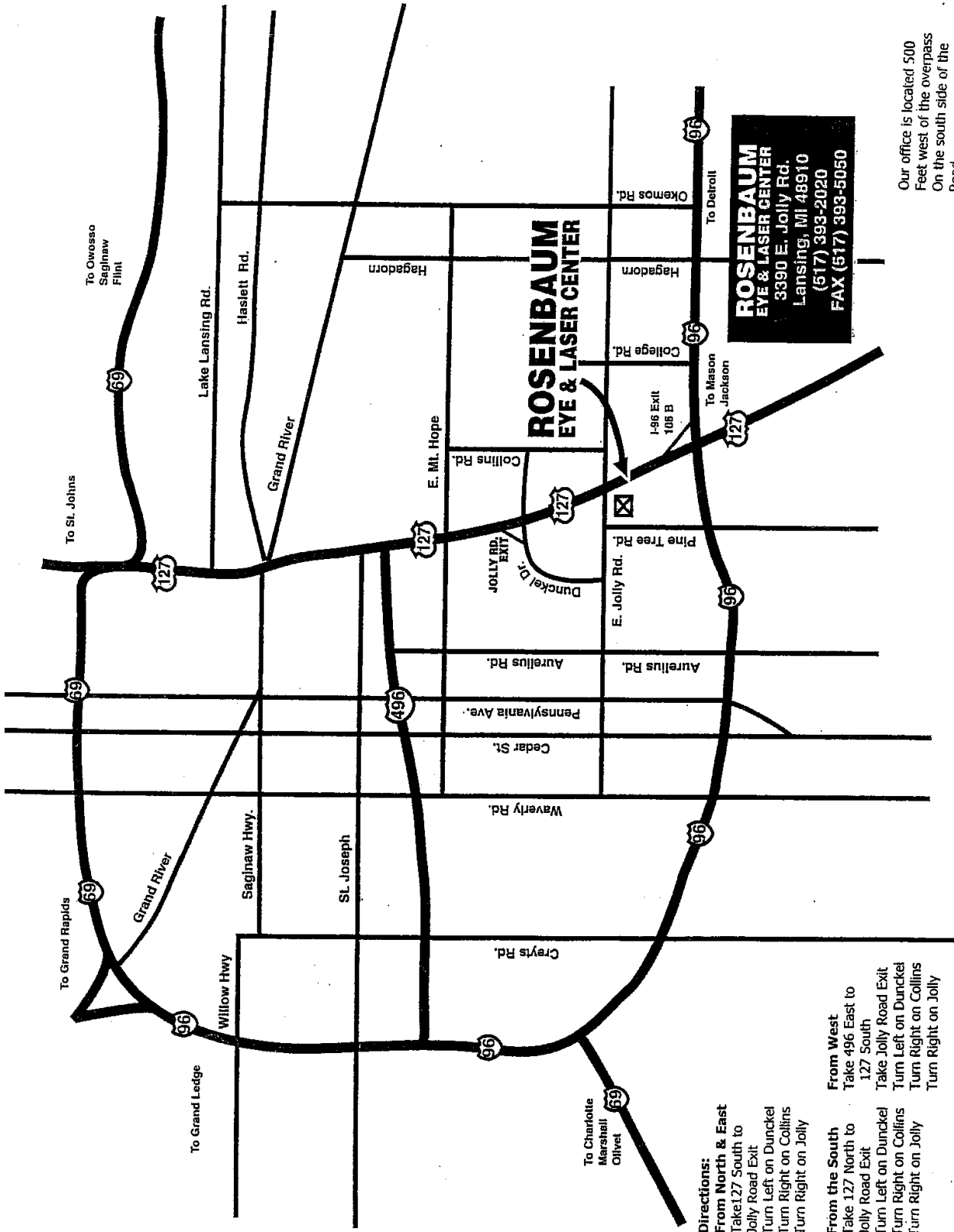
We look forward to serving your needs.

Sincerely,

Refractive Coordinators

SABRINA: 517-393-2020, EXT 206 OR SYANG@ROSENBAUMEYE.COM
JODI: 517-393-2020 EXT, 225 OR JFELDPUSCH@ROSENBAUMEYE.COM

3390 E. Jolly Rd Lansing, MI 48910 (517) 393-2020



**ROSENBAUM
EYE & LASER CENTER**
3390 E. Jolly Rd.
Lansing, MI 48910
(517) 393-2020
FAX (517) 393-5050

Directions:
From North & East
Take I-127 South to
Jolly Road Exit
Turn Left on Dunckel
Turn Right on Collins
Turn Right on Jolly

From the South
Take I-127 North to
Jolly Road Exit
Turn Left on Dunckel
Turn Right on Collins
Turn Right on Jolly

From West
Take 496 East to
I-127 South
Take Jolly Road Exit
Turn Left on Dunckel
Turn Right on Collins
Turn Right on Jolly

Our office is located 500
Feet west of the overpass
On the south side of the
Road.

**ROSENBAUM EYE & LASER CENTER
PATIENT REGISTRATION FORM**

LEGAL NAME _____ TODAY'S DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL _____

SEX: MALE / FEMALE DATE OF BIRTH _____ AGE _____ MARTIAL STATUS S M D W

E-MAIL ADDRESS _____ SOCIAL SECURITY # _____

DRIVER'S LICENSE # _____ OCCUPATION _____

EMPLOYER _____ ADDRESS _____

SPOUSE'S NAME _____ DATE OF BIRTH _____ WORK # _____

SPOUSE'S SOCIAL SECURITY # _____

EMERGENCY CONTACT _____ PHONE # _____

PRIMARY CARE DOCTOR _____ PHONE # _____

PRIMARY OPTOMETRIST _____ PHONE # _____

INSURANCE INFORMATION

INSURED'S NAME _____ DATE OF BIRTH _____ NAME OF INSURANCE _____

INSURED'S NAME _____ DATE OF BIRTH _____ NAME OF INSURANCE _____

IF BILLS ARE NOT TO BE SENT TO THE PATIENT, PLEASE LIST RESPONSIBLE PARTY INFORMATION BELOW

NAME _____ RELATIONSHIP TO PATIENT _____ SS#: _____

ADDRESS _____ CITY _____ MI _____ ZIP _____

HOME # _____ WORK # _____

~~~~~

**REASON FOR VISIT:**

\_\_\_\_\_

**REFERRED BY:**

\_\_\_\_\_

THERE WILL BE A \$30 FEE FOR CANCELLING OR MISSING AN APPOINTMENT WITH LESS THAN 24 HOURS NOTICE.



FRANK ROSENBAUM, M.D.  
CHRIS KRAMER, O.D.

LANCE C. LEMON, M.D.  
A. BAWA DASS, M.D.

M. DONNA QAHWASH, D.O.  
JEREMY WOLFE, M.D.

PHONE:  
LANSING ~ 517-393-2020  
OWOSSO ~ 989-729-2020

FAX:  
LANSING ~ 888-972-3936  
OWOSSO ~ 989-729-8205

**AUTHORIZATION TO RELEASE  
PROTECTED HEALTH INFORMATION (PHI)**

PATIENTS NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

I AUTHORIZE THE PERSONS NAMED BELOW TO REVIEW MY MEDICAL RECORDS, OR INQUIRE ABOUT MY CARE.

| NAME | RELATIONSHIP | PHONE |
|------|--------------|-------|
|      |              |       |
|      |              |       |
|      |              |       |
|      |              |       |
|      |              |       |
|      |              |       |

I HAVE READ, (OR HAVE HAD READ TO ME) THE ABOVE EXPLANATION OR AUTHORIZATION OF PROTECTED HEALTH INFORMATION.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT SIGNATURE

OR

I REFUSE TO HAVE ANY OF MY PROTECTED HEALTH INFORMATION RELEASED TO ANYONE UNLESS A WRITTEN AUTHORIZATION IS SIGNED. THIS DOES NOT INCLUDE DISCLOSURES FOR PURPOSES OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT SIGNATURE

# ROSENBAUM EYE & LASER CENTER

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ DATE \_\_\_\_\_

YOUR DOCTOR WHO: REFERRED YOU HERE \_\_\_\_\_  
PRIMARY CARE \_\_\_\_\_  
PRIMARY OPTOMETRIST \_\_\_\_\_

YOUR LOCAL PHARMACY: \_\_\_\_\_

REASON FOR VISIT: \_\_\_\_\_

DO YOU CURRENTLY HAVE? (CHECK ALL THAT APPLY)

- |                                                      |                                                    |                                                   |
|------------------------------------------------------|----------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> EYE DISCOMFORT              | <input type="checkbox"/> BLURRY VISION             | <input type="checkbox"/> GLARE AROUND LIGHTS      |
| <input type="checkbox"/> SPOTS OR FLOATERS IN VISION | <input type="checkbox"/> FLASHING LIGHTS IN VISION | <input type="checkbox"/> HALOS AROUND LIGHTS      |
| <input type="checkbox"/> TEARING OR DISCHARGE        | <input type="checkbox"/> REDNESS                   | <input type="checkbox"/> REDUCED DEPTH PERCEPTION |
| <input type="checkbox"/> BLIND SPOT IN VISION        | <input type="checkbox"/> DOUBLE VISION             | <input type="checkbox"/> REDUCED NIGHT VISION     |
| <input type="checkbox"/> FLUCTUATING VISION          | <input type="checkbox"/> REDUCED COLOR VISION      | <input type="checkbox"/> OTHER EYE COMPLAINTS     |

EXPLAIN ALL OF THE ABOVE CHECKED:

HAVE YOU EVER HAD OR DO YOU HAVE? (CHECK ALL THAT APPLY)

- |                                                  |                                               |                                                 |
|--------------------------------------------------|-----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> EYE SURGERY             | <input type="checkbox"/> EYE LASER TREATMENT  | <input type="checkbox"/> EYE INJURY             |
| <input type="checkbox"/> LAZY EYE                | <input type="checkbox"/> CROSSED EYES         | <input type="checkbox"/> EYE PATCHING TREATMENT |
| <input type="checkbox"/> STEROID EYE MEDICATIONS | <input type="checkbox"/> OTHER EYE TREATMENTS | <input type="checkbox"/> GLAUCOMA               |
| <input type="checkbox"/> MACULAR DEGENERATION    | <input type="checkbox"/> CATARACTS            | <input type="checkbox"/> ELEVATED EYE PRESSURE  |
| <input type="checkbox"/> OTHER EYE CONDITIONS    |                                               |                                                 |

EXPLAIN ALL OF THE ABOVE CHECKED:

WHAT IS YOUR HIGHEST RECORDED EYE PRESSURE IF KNOWN FOR EACH EYE? \_\_\_\_\_ (RIGHT) \_\_\_\_\_ (LEFT).

IS BLURRY VISION IN EITHER EYE INTERFERING WITH ANY OF THESE ACTIVITIES? (CHECK ALL THAT APPLY)

- |                                                  |                                              |                                                    |
|--------------------------------------------------|----------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> READING                 | <input type="checkbox"/> SEEING STREET SIGNS | <input type="checkbox"/> WATCHING TV               |
| <input type="checkbox"/> DRIVING                 | <input type="checkbox"/> HOBBIES             | <input type="checkbox"/> DAILY ACTIVITIES & CHORES |
| <input type="checkbox"/> OTHER ACTIVITIES (LIST) |                                              |                                                    |

LIST ALL EYE MEDICATIONS:

| NAME  | WHICH EYE | TIMES PER DAY |
|-------|-----------|---------------|
| _____ | _____     | _____         |
| _____ | _____     | _____         |
| _____ | _____     | _____         |
| _____ | _____     | _____         |

LIST EYE MEDICATION ALLERGIES AND INTOLERANCES:

DOES ANY CLOSE RELATIVE (FATHER, MOTHER, SISTER, BROTHER, SON OR DAUGHTER) HAVE A HISTORY OF?

- |                                   |                                            |                                                  |
|-----------------------------------|--------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> OTHER EYE DISEASE | <input type="checkbox"/> OTHER INHERITED DISEASE |
|-----------------------------------|--------------------------------------------|--------------------------------------------------|

EXPLAIN ALL OF THE ABOVE CHECKED:

# ROSENBAUM EYE & LASER CENTER

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ DATE \_\_\_\_\_

CHECK ALL CONDITIONS YOU HAVE HAD AND ANY SYMPTOMS THAT YOU HAVE NOW:

| SYSTEM                 | CONDITION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | SYMPTOM                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CONSTITUTIONAL         | <input type="checkbox"/> CHRONIC FATIGUE SYNDROME                                                                                                                                                                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> FEVER, FATIGUE, <input type="checkbox"/> INSOMNIA, <input type="checkbox"/> NIGHT SWEATS, <input type="checkbox"/> WEIGHT GAIN, <input type="checkbox"/> WEIGHT LOSS                                                                                                                                                                                                                                                           |
| EYE, EAR, NOSE, THROAT | <input type="checkbox"/> SINUS TROUBLE, <input type="checkbox"/> COCHLEAR IMPLANT, <input type="checkbox"/> TMJ, HEARING LOSS                                                                                                                                                                                                                                                                                                                                                                | <input type="checkbox"/> JAW PAIN WITH CHEWING                                                                                                                                                                                                                                                                                                                                                                                                          |
| RESPIRATORY            | <input type="checkbox"/> ASTHMA, <input type="checkbox"/> EMPHYSEMA, <input type="checkbox"/> CHRONIC BRONCHITIS, <input type="checkbox"/> COPD, <input type="checkbox"/> TUBERCULOSIS, <input type="checkbox"/> HOME OXYGEN USE                                                                                                                                                                                                                                                             | <input type="checkbox"/> SHORT OF BREATH, <input type="checkbox"/> COUGH, <input type="checkbox"/> WHEEZING, <input type="checkbox"/> PAIN WITH BREATHING                                                                                                                                                                                                                                                                                               |
| CARDIOVASCULAR         | <input type="checkbox"/> HYPERTENSION, <input type="checkbox"/> CORONARY ARTERY DISEASE, <input type="checkbox"/> CONGESTIVE HEART FAILURE, <input type="checkbox"/> HEART ATTACK, <input type="checkbox"/> HEART DISEASE, <input type="checkbox"/> POOR CIRCULATION OF EXTREMITIES, <input type="checkbox"/> IRREGULAR HEART RATE OR RHYTHM, <input type="checkbox"/> SHOCK, <input type="checkbox"/> RAYNAUD'S, <input type="checkbox"/> PACEMAKER, <input type="checkbox"/> DEFIBRILLATOR | <input type="checkbox"/> HIGH BLOOD PRESSURE, <input type="checkbox"/> ANGINA, <input type="checkbox"/> PALPITATIONS, <input type="checkbox"/> SHORT OF BREATH LAYING FLAT, <input type="checkbox"/> LEG SWELLING, <input type="checkbox"/> FLUID IN LUNGS, <input type="checkbox"/> EXCEPTIONAL COLD INTOLERANCE, <input type="checkbox"/> FAST HEART RATE, <input type="checkbox"/> SLOW HEART RATE, <input type="checkbox"/> CALF PAIN WITH EXERCISE |
| GASTROINTESTINAL       | <input type="checkbox"/> LIVER DISEASE, <input type="checkbox"/> HEPATITIS, <input type="checkbox"/> CIRRHOSIS                                                                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> ABDOMEN PAIN, <input type="checkbox"/> BLACK TARRY STOOLS, <input type="checkbox"/> BLOODY STOOL, <input type="checkbox"/> CONSTIPATION, <input type="checkbox"/> DECREASED APPETITE, <input type="checkbox"/> DIARRHEA, <input type="checkbox"/> JAUNDICE, <input type="checkbox"/> NAUSEA, <input type="checkbox"/> VOMITING, <input type="checkbox"/> DIFFICULTY SWALLOWING                                                 |
| GENITOURINARY          | <input type="checkbox"/> KIDNEY DISEASE, <input type="checkbox"/> KIDNEY STONE, <input type="checkbox"/> FLOMAX USE NOW OR IN PAST,                                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> BLOODY URINE, <input type="checkbox"/> PAINFUL URINATION, <input type="checkbox"/> URINARY URGENCY, <input type="checkbox"/> ABNORMAL MENSTRUATION, <input type="checkbox"/> URINARY DISCHARGE                                                                                                                                                                                                                                 |
| INTEGUMENTARY          | <input type="checkbox"/> ACNE, <input type="checkbox"/> ROSACEA, <input type="checkbox"/> LATEX ALLERGY, <input type="checkbox"/> ACCUTANE OR ISOTRETINOIN USE                                                                                                                                                                                                                                                                                                                               | <input type="checkbox"/> SKIN RASH, <input type="checkbox"/> SKIN LUMP, <input type="checkbox"/> ABNORMAL SKIN LESION,                                                                                                                                                                                                                                                                                                                                  |
| ENDOCRINE              | <input type="checkbox"/> DIABETES TYPE 1 OR TYPE 2 (PLEASE CIRCLE)<br><input type="checkbox"/> THYROID DISORDER, <input type="checkbox"/> HIGH CHOLESTEROL                                                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> HIGH BLOOD SUGAR, <input type="checkbox"/> HIGH CHOLESTEROL, <input type="checkbox"/> INCREASED THIRST, <input type="checkbox"/> BULGING EYES, <input type="checkbox"/> INCREASED URINATION, <input type="checkbox"/> COLD INTOLERANCE                                                                                                                                                                                         |
| NEUROLOGICAL           | <input type="checkbox"/> STROKE, <input type="checkbox"/> MINI-STROKE, <input type="checkbox"/> TIA (TRANSIENT ISCHEMIC ATTACK), <input type="checkbox"/> CHRONIC HEADACHES, <input type="checkbox"/> MIGRAINES                                                                                                                                                                                                                                                                              | <input type="checkbox"/> DIZZINESS, <input type="checkbox"/> HEADACHE, <input type="checkbox"/> SEIZURES, <input type="checkbox"/> BALANCE PROBLEM, <input type="checkbox"/> LOCAL WEAKNESS, <input type="checkbox"/> NUMBNESS, <input type="checkbox"/> MEMORY PROBLEMS                                                                                                                                                                                |
| PSYCHOLOGICAL          | <input type="checkbox"/> DEMENTIA, <input type="checkbox"/> ALZHEIMERS, <input type="checkbox"/> SCHIZOPHRENIA, <input type="checkbox"/> DEPRESSION, <input type="checkbox"/> ANXIETY                                                                                                                                                                                                                                                                                                        | <input type="checkbox"/> LOW MOOD, <input type="checkbox"/> ELEVATED MOOD, <input type="checkbox"/> NERVOUSNESS, <input type="checkbox"/> HALLUCINATIONS, <input type="checkbox"/> EMOTIONAL DISORDER                                                                                                                                                                                                                                                   |
| MUSCULOSKELETAL        | <input type="checkbox"/> ARTHRITIS, <input type="checkbox"/> RHEUMATOID, <input type="checkbox"/> MYASTHENIA GRAVIS, <input type="checkbox"/> JOINT REPLACEMENT SURGERY                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> JOINT PAIN, <input type="checkbox"/> WEAKNESS, <input type="checkbox"/> JOINT STIFFNESS                                                                                                                                                                                                                                                                                                                                        |
| HEMATOLOGIC/LYMPHATIC  | <input type="checkbox"/> BLOOD TRANSFUSION, <input type="checkbox"/> BLOOD DISORDER, <input type="checkbox"/> ANEMIA, <input type="checkbox"/> COUMADIN OR BLOOD THINNER USE                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> BRUISING, <input type="checkbox"/> BLEEDING, <input type="checkbox"/> ENLARGED LYMPH NODES                                                                                                                                                                                                                                                                                                                                     |
| IMMUNOLOGICAL          | <input type="checkbox"/> SEASONAL OR ENVIRONMENTAL ALLERGIES, <input type="checkbox"/> HIV/AIDS                                                                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> HIVES                                                                                                                                                                                                                                                                                                                                                                                                                          |
| OTHER (LIST)           | <input type="checkbox"/> CANCER (LIST BELOW), <input type="checkbox"/> MAJOR SURGERIES (LIST BELOW)                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

DESCRIBE ABOVE: \_\_\_\_\_

LIST ALL REGULAR MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS: (OTC OR PRESCRIBED)

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

LATEX ALLERGY: PLEASE CHECK:  YES  NO HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ PREGNANT:  YES  NO OXYGEN USE:  YES  NO  
 NURSING:  YES  NO  24 HRS  AS NEEDED

LIST ALL ALLERGIES TO MEDICATIONS:  
 \_\_\_\_\_  
 \_\_\_\_\_

DO YOU USE OR HAVE YOU USED IN THE PAST?  
 ALCOHOL:  YES  NO  IN THE PAST \_\_\_\_\_ TIMES PER (WEEK / MONTH)  
 TOBACCO:  YES  NO  IN THE PAST \_\_\_\_\_ PACKS PER DAY FOR \_\_\_\_\_ YEARS  
 CAFFEINE:  YES  NO  IN THE PAST \_\_\_\_\_ (CUPS / DRINKS) PER DAY  
 RECREATIONAL DRUGS:  YES  NO  IN THE PAST TYPES \_\_\_\_\_

What Best Describes your Ethnic Background?  
 WHITE / CAUCASIAN  AFRICAN-AMERICAN  NATIVE-AMERICAN  ASIAN  HISPANIC  OTHER \_\_\_\_\_

## Signature on File, Assignment of Benefits, Financial Agreement

\_\_\_\_\_  
Printed Patient Name

\_\_\_\_\_  
Patient Date of Birth

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**MEDICARE:** I request that payment of authorized Medicare benefits be made on my behalf to Rosenbaum Eye and Laser Center for services furnished to me by Rosenbaum Eye and Laser Center. 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 or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated, my signature authorizes releasing the information to the insurer or agency shown. Rosenbaum Eye and Laser Center accepts the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance and non-covered services. Coinsurance and deductible based upon the charge determination of the Medicare Carrier.

**OTHER INSURANCE:** I understand that Rosenbaum Eye and Laser Center maintains a list of health care service plans which it contracts. A list of such plans is available from the business office, and that Rosenbaum Eye and Laser Center has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by Rosenbaum Eye and Laser Center if I belong to a plan that does not appear on the above mentioned list.

**RELEASE OF INFORMATION:** Rosenbaum Eye and Laser Center may disclose all or part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or maybe liable or under contract to Rosenbaum Eye and Laser Center for reimbursement for services rendered, and (2) any health care provider for continued patient care. Rosenbaum Eye and Laser Center may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, and medical research, for the collection of statistical data or pursuant to state or federal law, statute or regulation. A copy of this authorization may be used in place of the original.

**NON-COVERED SERVICES:** I understand that Rosenbaum Eye and Laser Center contracts with health care service plans (i.e., HMO's, PPO's) state items and services which are "covered" by the health care service plans. Accordingly, the undersigned accepts full responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient; and treatment or test not authorized by the health care service plan. The undersigned agrees to cooperate with Rosenbaum Eye and Laser Center to obtain necessary health care service plan authorizations.

**FINANCIAL AGREEMENT:** I agree that in return for their services provided to the patient by Rosenbaum Eye and Laser Center, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to Rosenbaum Eye and Laser Center for payment. If an account is sent to any attorney for collection, I agree to pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, are hereby assigned to Rosenbaum Eye and Laser Center. If co-payments and /or deductibles are designated by my insurance company or health plan, I agree to pay them to Rosenbaum Eye and Laser Center. However, it is understood that the undersigned and /or the patient are primarily responsible for the payment of my bill.

\_\_\_\_\_  
Patient Signature or Authorized Party

\_\_\_\_\_  
Date