Rosenbaum Eye & Laser Center

FRANK ROSENBAUM, M.D. ERICA PERSON, M.D. LANCE C. LEMON, M.D.

CHRIS KRAMER, O.D.

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

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

THANK YOU FOR CHOOSING ROSENBAUM EYE & LASER CENTER TO TREAT AND ASSIST YOU IN YOUR EYE CARE NEEDS.
PLEASE ARRIVE 20 MINUTES BEFORE YOUR SCHEDULED APPOINTMENT TIME.

YOU HAVE AN APPOINTMENT ON _____ AT _____ A.M. / P.M. TO SEE _____ IN LANSING.

PLEASE BRING THE FOLLOWING ITEMS WITH YOU TO YOUR UPCOMING APPOINTMENT:

- ✓ REGISTRATION AND HEALTH HISTORY FORM. PLEASE FILL OUT THESE FORMS AND BRING THEM WITH YOU TO YOUR APPOINTMENT.
- ✓ INSURANCE CARDS – BRING THE ORIGINAL CARD, NOT COPIES
- ✓ DRIVERS LICENSE OR PICTURE ID
- ✓ INSURANCE AUTHORIZATION (IF YOUR INSURANCE REQUIRES A REFERRAL, PLEASE CONTACT YOUR PRIMARY CARE PHYSICIAN & MAKE SURE WE HAVE IT PRIOR TO YOUR APPOINTMENT)
- ✓ CURRENT MEDICATIONS LIST
- ✓ PLEASE BRING POWER OF ATTORNEY FORMS IF IT APPLIES
- ✓ CATARACT EVAL PATIENTS SHOULD BE OUT OF CONTACTS 1-WK PER DECADE WORN FOR SOFT AND 2-WKS PER DECADE WORN FOR GAS PERM LENS, PRIOR TO THEIR APPOINTMENT.
- ✓ **YOUR EXAM MAY REQUIRE PUPIL DILATION THEREFORE YOU SHOULD BE PREPARED TO BRING A DRIVER**
- ✓ **SELF-PAY PATIENTS (WITHOUT MEDICAL INSURANCE) WILL BE RESPONSIBLE FOR A $75 CHECK-IN FEE, REMAINING BALANCE OR PAYMENT PLAN WILL BE ESTABLISHED UPON CHECK- OUT.**

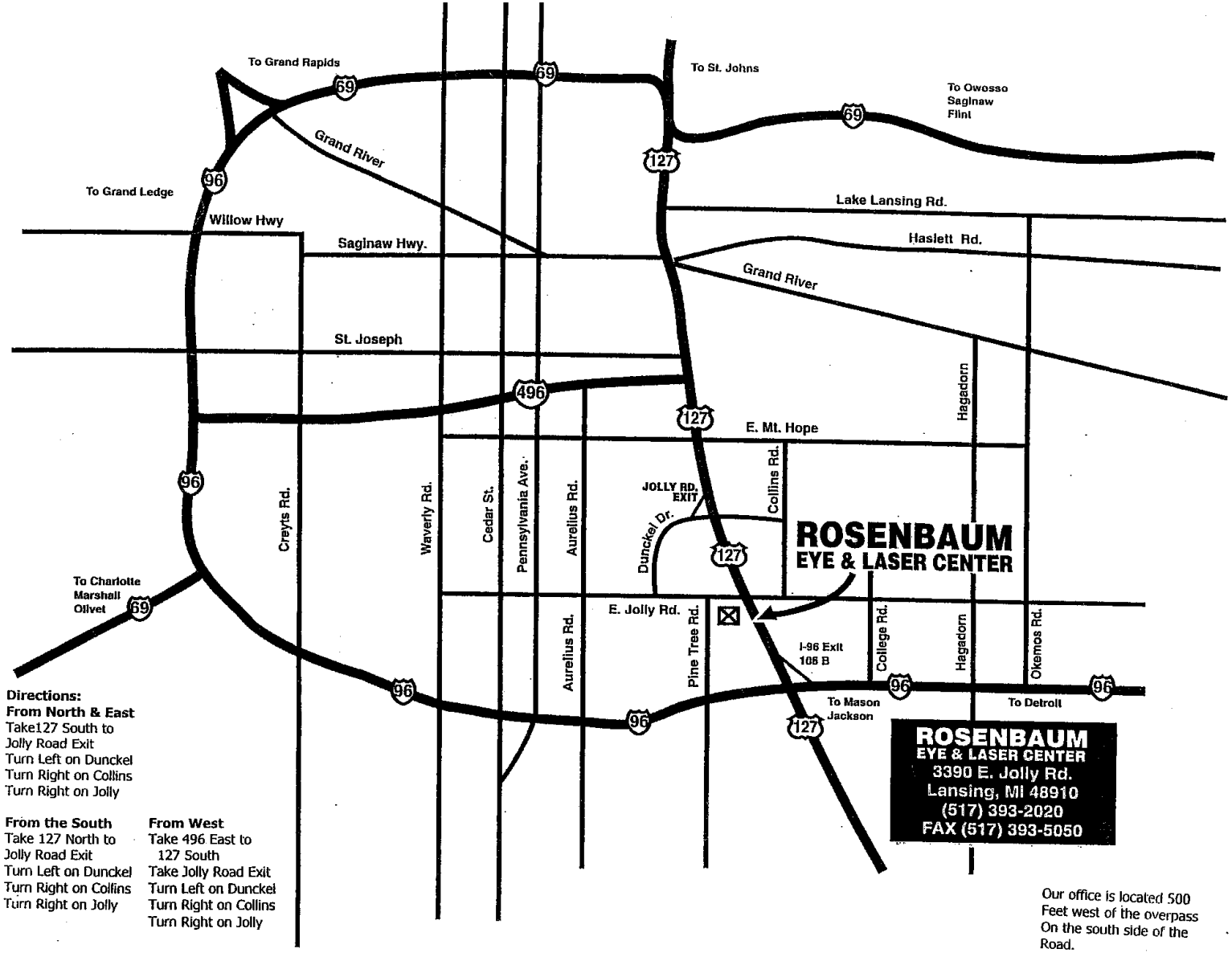
BE PREPARED TO PAY ANY CO-PAYS OR DEDUCTIBLES UPON CHECK IN.

WE ACCEPT PERSONAL CHECKS, CASH, MASTERCARD, VISA AND DISCOVER.

PLEASE ALLOW 2 HOURS FOR YOUR VISIT WITH US.

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

3390 E. JOLLY ROAD ~ LANSING, MI ~ 48910
802 W. KING STREET ~ SUITE A ~ OWOSSO, MI ~ 48867


To Grand Rapids
69
To St. Johns
To Owosso
Saginaw
Flint
Grand River
To Grand Ledge
96
127
Lake Lansing Rd.
Willow Hwy
Saginaw Hwy.
Haslett Rd.
Grand River
St. Joseph
496
127
E. Mt. Hope
Hagadorn
96
Creyts Rd.
Waverly Rd.
Cedar St.
Pennsylvania Ave.
Aurelius Rd.
JOLLY RD. EXIT
Dunckel Dr.
Collins Rd.
127
ROSENBAUM
EYE & LASER CENTER
To Charlotte
Marshall
Olivet
69
E. Jolly Rd.
Aurelius Rd.
Pine Tree Rd.
I-96 Exit
106 B
College Rd.
Hagadorn
Okemos Rd.
96
96
96
To Mason
Jackson
To Detroit
127
ROSENBAUM
EYE & LASER CENTER
3390 E. Jolly Rd.
Lansing, MI 48910
(517) 393-2020
FAX (517) 393-5050
Directions:
From North & East
Take127 South to
Jolly Road Exit
Turn Left on Dunckel
Turn Right on Collins
Turn Right on Jolly
From the South
Take 127 North to
Jolly Road Exit
Turn Left on Dunckel
Turn Right on Collins
Turn Right on Jolly
From West
Take 496 East to
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 _____ MARITAL STATUS S M D W

DRIVER'S LICENSE #_____ SOCIAL SECURITY # _____

E-MAIL ADDRESS _____ OCCUPATION _____

EMPLOYER _____ ADDRESS _____

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

SPOUSE'S SOCIAL SECURITY # _____LANGUAGE_____

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.

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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 _____

PRIMARY LOCAL PHARMACY (CITY /STREET) _____

MAIL ORDER PHARMACY:_____

DO YOU CURRENTLY HAVE? (CHECK ALL THAT APPLY)

- ❑ EYE DISCOMFORT
- ❑ BLURRY VISION
- ❑ GLARE AROUND LIGHTS
- ❑ SPOTS OR FLOATERS IN VISION
- ❑ FLASHING LIGHTS IN VISION
- ❑ HALOS AROUND LIGHTS
- ❑ TEARING OR DISCHARGE
- ❑ REDNESS
- ❑ REDUCED DEPTH PERCEPTION
- ❑ BLIND SPOT IN VISION
- ❑ DOUBLE VISION
- ❑ REDUCED NIGHT VISION
- ❑ FLUCTUATING VISION
- ❑ REDUCED COLOR VISION
- ❑ OTHER EYE COMPLAINTS

EXPLAIN ALL OF THE ABOVE CHECKED:
_____
_____

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

- ❑ EYE SURGERY
- ❑ EYE LASER TREATMENT
- ❑ EYE INJURY
- ❑ LAZY EYE
- ❑ CROSSED EYES
- ❑ EYE PATCHING TREATMENT
- ❑ STEROID EYE MEDICATIONS
- ❑ OTHER EYE TREATMENTS
- ❑ GLAUCOMA
- ❑ MACULAR DEGENERATION
- ❑ CATARACTS
- ❑ ELEVATED EYE PRESSURE
- ❑ 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)

- ❑ READING
- ❑ SEEING STREET SIGNS
- ❑ WATCHING TV
- ❑ DRIVING
- ❑ HOBBIES
- ❑ DAILY ACTIVITIES & CHORES
- ❑ OTHER ACTIVITIES (LIST)

_____

LIST ALL EYE MEDICATIONS:

NAME	WHICH EYE	TIMES PER DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

LIST EYE MEDICATION ALLERGIES & REACTION:
_____

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

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

DESCRIBE ABOVE: _____

LIST ALL MEDICATIONS & DOSAGE, VITAMINS, HERBALS AND OVER THE COUNTER:

_____

_____

_____

LATEX ALLERGY: PLEASE CHECK: ❑YES ❑NO HEIGHT____WEIGHT____ PREGNANT: ❑YES ❑NO OXYGEN USE: ❑YES ❑NO ❑24 HRS ❑ AS NEEDED

LIST ALL ALLERGIES & REACTIONS 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

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 of federal law, statue 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