Rosenbaum
Eye & Laser Center

"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.

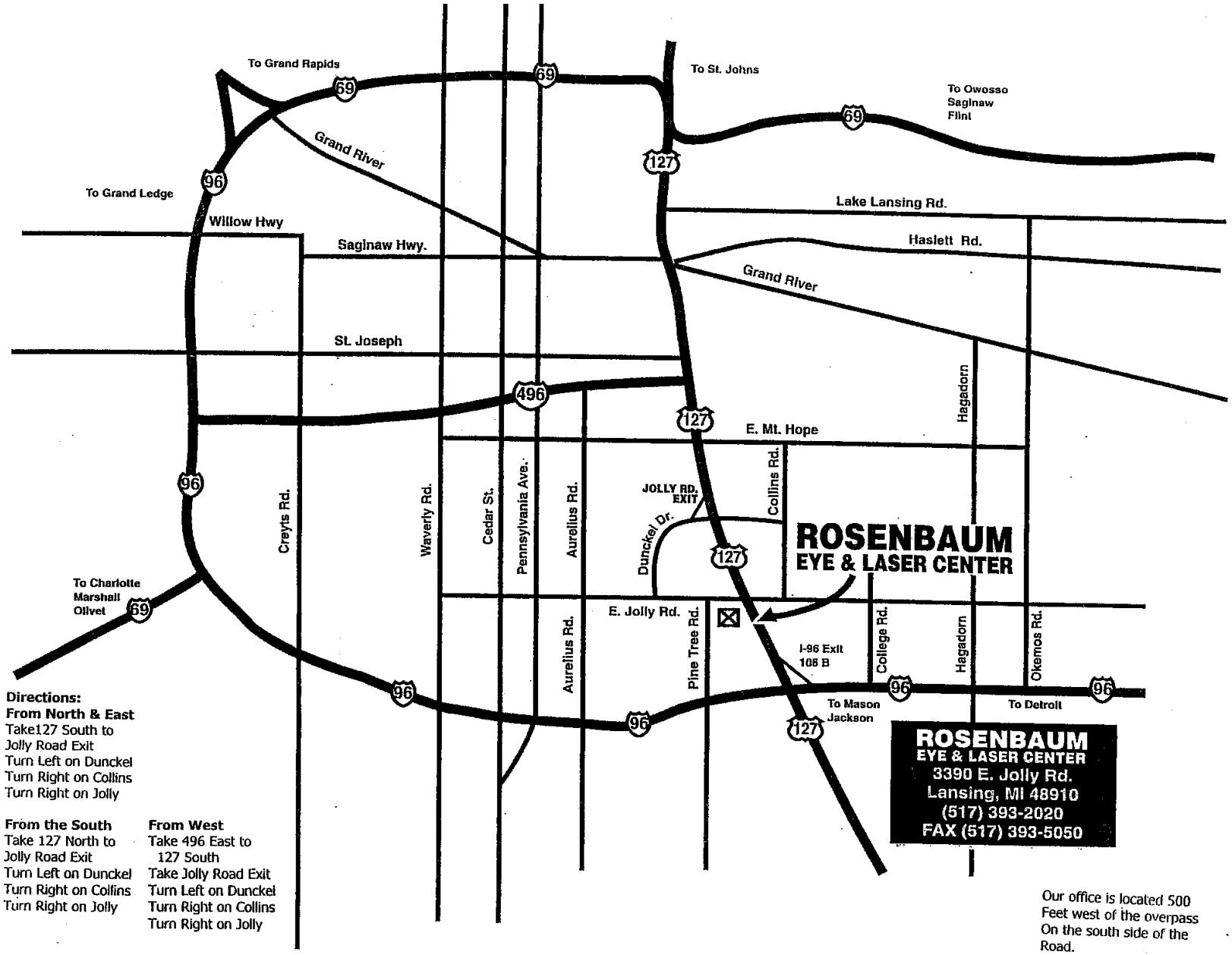
We have included a map to make it more convenient for you to find our office. If you have any questions or concerns before your appointment, please feel free to contact us.

We look forward to serving your needs.

Sincerely,

Refractive Coordinators

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



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

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

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.

Rosenbaum Eye & Laser Center

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

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

EXPLAIN ALL OF THE ABOVE CHECKED:

_____
_____

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

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

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

_____

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?

- ❑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 (TRANSIENT ISCHEMIC ATTACK), ❑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 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 _____

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 _____