traverse city eye
a clear vision of care.

PATIENT REGISTRATION INFORMATION

Please complete the following information. Ask our Receptionist if you need any assistance.

Primary Care Physician: _____ Today's Date: _____

PERSONAL INFORMATION

Legal Name: _____
(Last name) (First name) (Middle name)

Address: _____
(Street) (City) (State) (Zip code)

Phone #: _____ / _____ Email Address: _____
(Home) (Cell)

Date of Birth: _____ Age _____ Social Security #: ___-___-___ Sex: **M | F**
(Month/Date/Year)

Race: _____ Ethnicity: _____

Marital Status: **Married | Single | Widowed | Divorced** Occupation: _____

Employer: _____ Employer Address: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Phone #: _____ Relationship: _____

IF APPLICABLE, YOUR SECONDARY ADDRESS: SUMMER | WINTER

Address: _____
(Street) (City) (State) (Zip code)

Phone #: _____

IF APPLICABLE, GUARDIAN INFORMATION: (If patient is under 18 years old, OR has the Power of Attorney, please complete.)

Guardian's Name: _____

Address: _____
(Street) (City) (State) (Zip code)

Social Security #: ___-___-___ Employer: _____

Phone #: Home: _____ Cell: _____ Work: _____

TO SAFEGUARD YOUR PRIVACY:
What phone number should we use to call you with any information? _____

May we leave a message at this number? **YES | NO**

How would you prefer to be contacted? **TEXT | HOME PHONE | CELL PHONE | MAIL**

Who may we release information to? **SPOUSE | OTHER** Phone No.:_____

Name:_____Relationship:_____

_____PLEASE DO NOT RELEASE ANY INFORMATION WITHOUT MY CONSENT

WOULD YOU LIKE TO RECEIVE EMAILS OR TEXTS FROM US? **YES | NO** **If so, which services?**

- ☐ Appointment reminders
- ☐ Info/news/updates about your condition
- ☐ Prescription refills
- ☐ Optical department requests or questions
- ☐ Contact lens requests or questions
- ☐ Discounts/promotional offers/special events

How did you hear about TC Eye?

Friend/Relative | TC Eye Website | Other Website | Newspaper Ad | Referral | Phonebook | Radio Cable TV | Network TV – Program: _____ | Other:_____

Other family member(s) seen in our practice: _____

INSURANCE VERIFICATION

1. **Primary Medical Insurance: (If none, check here ☐)**

   Company Name:_____

   Policy Number:_____ **Group Number:**_____

   Subscribers Name:_____ **Subscribers DOB:**_____

   Subscribers Relationship to the Patient:_____

2. **Secondary Medical Insurance: (If none, check here ☐)**

   Company Name:_____

   Policy Number:_____ **Group Number:**_____

   Subscribers Name:_____ **Subscribers DOB:**_____

   Subscribers Relationship to the Patient:_____

3. **Vision Insurance: (If none, check here ☐)**

   Company Name:_____

   Policy Number:_____ **Group Number:**_____

   Subscribers Name:_____ **Subscribers DOB:**_____

   Subscribers Relationship to the Patient:_____

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PATIENT HISTORY

1. **Please list current medical conditions and approximate date of diagnosis:** **If none, check here ☐**

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

2. **Please list current ocular conditions and approximate date of diagnosis:** **If none, check here ☐**

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

3. **Please list prior ocular and bodily surgeries, injuries, and/or hospitalizations and approximate date of event:**

   If none, check here ☐

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

4. **Please indicate if you have a blood related relative with any of the following conditions:**

   If no relevant family history or unknown, check here ☐

Ocular Condition	Relationship	Systemic Condition	Relationship
Retinal Detachment ☐		**Diabetes ☐**	
Glaucoma ☐		**Hypertension ☐**	
Macular Degeneration ☐		**Heart Disease ☐**	
Cataracts ☐		**High Cholesterol ☐**	
Blindness ☐		**Cancer ☐**	
Strabismus/Lazy Eye ☐		**Thyroid Disease ☐**	
Other:		**Other:**	

5. **What is your tobacco use status?**

- ☐ **Never a smoker.**
- ☐ **Former smoker. For how many years? _____ Approximate cessation date:_____**
- ☐ **Current smoker. For how many years?_____Approximate use (e.g. packs/day)_____**

6. **When was your last eye exam and where?_____**
7. **When was your last physical exam and where?_____**
8. **Do you currently wear glasses? YES I NO Age of glasses: _____**
9. **Do you currently wear contacts? YES I NO Brand:_____**

10. **Please list all current ocular and systemic medications with milligram amount and dosing if applicable:**

If no current medications, check here ☐

Medication/Dosing	Medication/Dosing
1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

11. **Please list all medication and food allergies and type of reaction to said agent.**

If no known medication or food allergies, check here ☐

Medication/Food	Allergic Reaction
1.	
2.	
3.	
4.	
5.	
6.	

12. REVIEW OF SYSTEMS

Please check either the Yes or No box for each of the condition or symptom below.

Constitutional	**Yes**	**No**	**Endocrine**	**Yes**	**No**
Fever			Insulin Dependent Type 1 Diabetes		
Chills			Diabetes Type 2 –not on insulin		
Weight loss			Diabetes Type 2 –on insulin		
Other:			Thyroid Disease		
			Gout		
Neurological			Other:		
Headaches					
Loss of strength			**Cardiovascular**		
Memory loss			Chest pain		
Migraines			Dizziness		
MS			Shortness of breath		
Paralysis			High BP		
Numbness			Palpations		
Stroke			High cholesterol		
Other:			Irregular heart beat		
	Yes	**No**		**Yes**	**No**
Allergic/Immunologic			Mitral valve prolapse		
Hives			Cardio myopathy		
Eczema			Pacemaker		
Hay fever			Other:		
Seasonal allergies					
Environmental allergies			**Ears, Nose, Throat**		
Other:			Sore throat		
			Sinus trouble		
Respiratory			Stuffy nose		
COPD			Hearing loss		
Asthma			Coughing		
Other:			Other:		
Gastrointestinal			**Genitourinary**		
Heartburn/reflux			Frequent urination		
Nausea/vomiting			Painful urination		
Abdominal pain			Other:		
Constipation					
Cramping			**Neonatal**		
GERD			Premature Birth		
Crohn's			Other:		
IBS					
Diverticulitis			**Hematology/Lymph**		
Other:			Anemia		
			Bruising easily		
Musculoskeletal			Enlarged glands		
Arthritis			Other:		
Osteoarthritis					
Rheumatoid arthritis			**Psychiatric**		
Polymyalgia rheumatic			Alzheimer's		

Osteoporosis			Anxiety		
Osteopenia			Depression		
Joint pain/swelling			Mood swings		
Stiffness			Difficulty sleeping		
Back pain			Bipolar		
Fibromyalgia			Dementia		
Scoliosis			ADHD		
Other:			Other:		

AUTHORIZATION TO RELEASE INFORMATION

I _____ authorize Traverse City Eye to release and/or discuss information relevant to my care to the following individuals:

_____ Spouse (name)_____

_____Other (name and relationship_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been made aware of Traverse City Eye's Notice of the HIPAA Privacy Practices.

Patient Name __«Person_First_Name» «Person_Last_Name»_____

_____ _____

Signature or Guardian *Date*

Documentation of failure to obtain signed acknowledgment:

On _____, _____presented this Acknowledgment of Receipt Of Notice of Privacy Practices form to: _____The patient refused to provide a signature **when requested.**

PAYMENT OF SERVICES: Payment is expected when services are rendered unless other arrangements are made in advance. Co-payments are due on the date of service. Should your account become delinquent, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts. There will be a $25.00 processing fee for any non-sufficient checks received. Please speak to our billing department if you have any questions regarding this policy.

MEDICARE AND OTHER INSURANCE

I request that payment of authorized Medicare benefits or other health insurance benefits be made either by me, or on my behalf, to Traverse City Eye Consultants, for any services rendered to me by the staff or physicians of Traverse City Eye Consultants. I authorize the release of medical information or any other information about me to the Health Care Financial Administration (Medicare) and/or my insurance carrier. This information is to be used for the purpose of evaluating and administering benefits. Independent insurance benefits should be made payable directly to Traverse City Eye Consultants, P.C.

_____ Medicare _____ Other Insurance (name of carrier) _____

PLEASE NOTE: Having insurance is not a substitute for payment. It is your responsibility to pay the deductible, co-insurance and any other balances not paid by your insurance. We will file any participating primary insurance claims for you and we will also forward claims to your secondary insurance (s) as long as you provide complete and accurate information. We will assist you in receiving reimbursement from your insurance carriers: however, you are responsible for your bill and full payment is expected within 45 days of your visit.

I understand I am financially responsible for all charges and if my insurance pays me directly, rather than Traverse City Eye Consultants, PC, I agree to send payment in full to Traverse City Eye Consultants within that same week.

This release will be considered valid from the date indicated below and will remain in effect until such a time as I withdraw it in writing. I have read the above information and I fully understand it.

Patient Signature _____Date _____
(Or Guardian/POA)