Cedar Run
Eye Center

Patient Name: _____

Date of Appointment: _____

Time of Appointment: _____

Doctor: _____

Your Office Representative: _____

Welcome to Cedar Run Eye Center. We look forward to your visit with us!

Enclosed you will find: Registration Form
History Form
Patient check list with a map on the back side

Your evaluation usually includes dilation of the eyes. Dilation causes blurred vision and some patient's feel uncomfortable driving after their examination. For your safety and comfort, we recommend you bring a driver. Please limit the number of the family members to 1 or 2 due to limited seating and plan approximately 2 hours for your initial evaluation.

If you have any questions regarding your appointment, insurance coverage or payment options, please call our friendly staff at: (231) 929-3888 in our Traverse City office.

Patient Checklist

☐ Please bring your completed Registration and Health History papers to your appointment. This information is required to be updated at least every three years.

☐ List all medications, herbs and supplements and the dosages that you are taking on the history form or on a separate sheet of paper.

☐ Bring all eye drops that you are using to record how they are used or write down the names of each eye medication and how often you use each.

☐ Bring your medical and vision insurance cards. If your insurance requires a referral, please contact you primary care physician before your appointment.

☐ Expect to pay your co-pays and non-covered services on the day of service.

☐ Contact lens wearers, please wear your contacts to your appointment if able.

☐ Do not wear your contacts if you are coming in for a surgical evaluation, such as cataract surgery. Call our office for a timeline regarding how long you should be out of contacts.

☐ Sunglasses to wear (for eye comfort after dilation).

☐ Bring your current prescription eye glasses.

Experience the Difference Experience Makes
Dr. Hanley is the owner of Cedar Run Eye Center and The Surgery Center

Patient Registration

Required Information - Please Fill In All Areas ***Today's Date:____/____/_____***

Contact Information

_____-_____-_____
Social Security Number

_____ __ _____ Title:_____ (Dr. Mr. Mrs. Ms. Rev.)
First Name MI Last Name

_____ _____ _____ _____
Mailing Address City State Zip Code

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ _____
Home Phone Cell l Other Phone

☐ Male
☐ Female

_____
Current Occupation or Retired As

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Other:

____/____/_____ _____
Date Of Birth Age

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

_____ _____
Employer Name & Address Work Phone

Primary Language: ☐ English ☐ Spanish ☐ Other:

_____
Email Address May we contact you by email? ☐ yes ☐ no

Status

Marital Status	Employment	Student Status	How did you hear about us?
☐ Single	☐ Full Time	☐ Full Time	☐ Friend/Family
☐ Married	☐ Part Time	☐ Part Time	☐ Doctor
☐ Divorced	☐ Retired		☐ Newspaper
☐ Widowed	☐ Self Employed		☐ Phone Book
☐ Separated	☐ Not Employed		☐ Other

Please List All Doctors

Family Dr._____
Cardiologist_____
Optometrist_____
Ophthalmologist_____
Other_____

Spouse

_____ _____
Spouse's Full Name Spouse's Occupation/Employer

_____/_____/_____ _____-_____-_____ _____
Spouse's Date of Birth Spouse's SS# Spouse's Work Phone #

_____ _____ _____
Emergency Contact Relationship Phone #

Fill out below if information applies

Guardian

Guardian/Responsible Party Info:

_____ ____ _____ ____/___/____
First Name MI Last Name Date of Birth

____-____-_____ _____ _____ _____ _____
Guardian SS# Mailing Adress City State Zip Code

_____ _____ _____
Occupation Employer Work Phone

Other Address

Secondary Address: Summer/Winter *Months Residing at this Address:*_____

_____ _____ _____ _____
Mailing Address City State Zip Code

_____
Phone

Health History Questionnaire

Please complete <u>both sides</u>

name label

Medical History

Check only the areas that apply to you:

- □ Atrial Fibrillation
- □ Congestive Heart Failure
- □ Heart Attack (MI)
- □ High Blood Pressure
- □ High Cholesterol
- □ Thyroid Disease □ High □ Low
- □ Peripheral Vascular Disease
- □ Diabetes Insulin? □ Yes □ No
- □ Gastric Reflux
- □ Hepatitis: □ B □ C □ other
- □ Stomach Ulcers
- □ Blood Clots
- □ HIV
- □ Sexually Transmitted Diseases
- □ Migraines
- □ Stroke
- □ TIA
- □ Dialysis
- □ Kidney Failure
- □ History of MRSA Infection
- □ History of C-Diff
- □ History of VRE
- □ Cancer (site):_____
- □ Asthma
- □ COPD (emphysema)
- □ Sleep Apnea- □ Use CPAP
- □ History of TB
- □ Chronic Pain (where)_____
- □ Rheumatoid Arthritis or Arthritis

Eye History (indicate which eye)

Check only the areas that apply to you:

- □ Diabetic Eye Disease □ Right □ Left
- □ Glaucoma □ Right □ Left
- □ Macular Degeneration □ Right □ Left
- □ Cataracts □ Right □ Left
- □ Cataract Surgery □ Right □ Left
- □ Laser Surgery: Type:_____ □ Right □ Left
- □ Eye Injury □ Right □ Left
- □ Crossed or Lazy Eye □ Right □ Left
- □ Retinal Detachment □ Right □ Left
- □ Loss of Eye □ Right □ Left
- □ LASIK or RK surgery □ Right □ Left

Family History (which family member)

Check only the areas that apply:

- □ Heart Disease _____
- □ Cancer _____
- □ Stroke _____
- □ Diabetes _____
- □ Hypertension _____
- □ Macular Degeneration _____
- □ Glaucoma _____
- □ Retinal Detachment _____
- □ Blindness _____
- □ Bleeding or Clotting issues _____
- □ Tumors of the Eye _____

Other:_____

Surgeries

Check only the areas that apply to you:

- □ Eye Surgery_____
- □ Appendix
- □ Joint Replacement _____
- □ Gall Bladder
- □ Aneurysm Repair
- □ Angioplasty
- □ Cardiac Stent
- □ Coronary Bypass
- □ Heart Valve Replacement
- □ Hysterectomy
- □ Tubal Ligation
- □ Mastectomy: □ Right □ Left
- □ Prostate Surgery
- □ Pacemaker
- □ ICD (defibrillator)

Height:_____

Weight:_____

<u>Other Surgeries</u>

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications

Please list or bring list with you

Med: **Strength:** **Times per day:**

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

□ See Attached List

Allergies to Medications

□ None

Medication	*Reaction*
_____	_____
_____	_____
_____	_____
_____	_____

Do you have a Latex Allergy? □ yes □ no

Do you have an Advance Medical Directive? □ yes □ no

Social History

Check only the areas that apply to you:

- □ Drink Alcohol?
- □ Drink Caffeinated Beverages?
- □ Medical Marijuana Use?
- □ Smoke? Packs per day?_____
  Quit?___When?_____
- □ Recreational Drugs?
  Last Use?_____
- □ Do you live alone?
- □ Are you afraid of a partner/anyone?
- □ Traveled outside of the U.S. in the last month?

Please Turn Over
And Fill In Back Section

Review of Systems-Have you had any of these symptoms in the **PAST 30 DAYS** Please check all that apply.

name label

Check only the areas that apply to you:

Constitutional:
□ Fever
□ Weight Loss
□ Fatigue

Eyes:
□ Recent changes in vision
□ Eye Pain
□ Decrease in Vision

Ears, Nose, Throat:
□ Dry Mouth
□ Sore Throat
□ Hearing Loss
□ Hearing Aids □ Right □ Left

Heart/Cardiovascular:
□ Chest Pain
□ Blood Pressure under control
□ Irregular Heart Beats

Lungs/Respiratory:
□ Difficulty Breathing
□ Cough - Is it Productive? Y/N
□ Coughing Blood?

Gastrointestinal:
□ Nausea
□ Jaundice or Yellow Skin
□ Abdominal Pain

Genitourinary:
□ Blood in Urine
□ Pain/Burning Urination
□ Kidney Problems

For Females*:*
□ Are or Could You Be Pregnant?
Last Menstrual Period_____
□ Are you Postmenopausal?

Musculoskeletal:
□ Joint Pain
□ Muscle Aches
□ Difficulty lying flat

Integumentary/Skin:
□ Rash
□ Skin Sores
□ Skin Cancer

Neurologic:
□ Dizziness
□ Weakness/Numbness
□ Seizures

Mental Status/Psychiatric:
□ Anxiety
□ Depression
□ Change in sleep pattern
□ Bipolar

Endocrine:
□ Blood Sugar Under Control
□ Heat/Cold Intolerance
□ Excessive Thirst

Blood/Lymph:
□ Easy Bruising/Bleeding
□ Prolonged Bleeding
□ Swollen Glands

Allergic/Immunologic:
□ HIV/AIDS
□ Lupus/Sjogrens
□ Seasonal Allergies

(If applicable) Please answer these additional questions:

Please Rate Your Pain (circle): no pain 1 2 3 4 5 6 7 8 9 10 severe pain

Have You Experienced Nausea or Vomiting After Surgery In The Past? □ Yes □ No

Pharmacy(s):_____

Location of Pharmacy:_____

Patient Phone Number(s):_____

Emergency Contact:_____ **Phone:**_____

Patient Signature:_____**Date:**_____

Initial:____ Date:_____ Initial:____ Date:_____ Initial:____ Date:_____

Reviewed by:
Initial Date

_____
_____
_____
_____
_____
_____
_____

Cedar Run
Eye Center

MEDICARE AND ALL INSURANCE POLICY HOLDERS

☐ Please present <u>all</u> insurance cards, including your medical and vision insurance cards when you check in for your appointment.

☐ Please plan to show your insurance cards at every visit.

☐ Some Medicare policies are through HMO's. If this applies to your policy, or if you have an HMO that is secondary to Medicare, <u>you</u> must obtain a referral from your primary care physician (PCP) prior to your visit and inform our staff that you have done so. Otherwise, your insurance will not help pay for services and you will owe 100%. Please inform our staff of the type of policy you have.

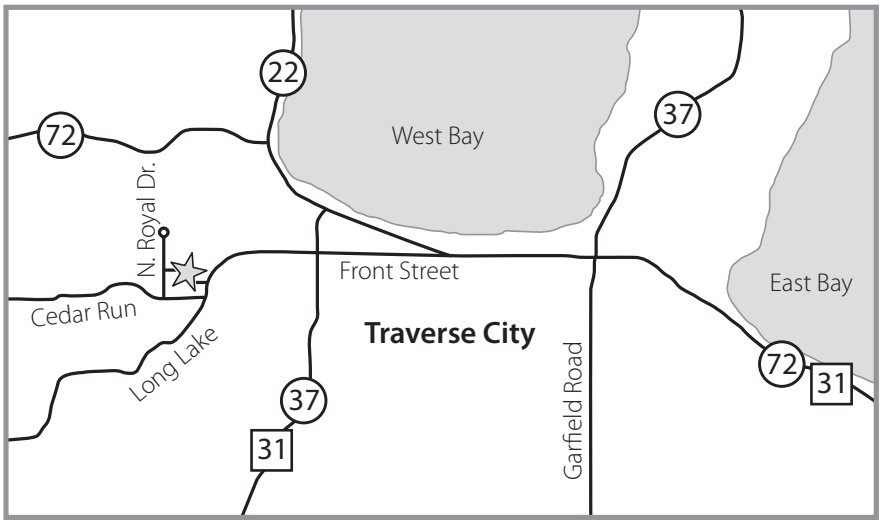
☐ Medicare does not cover all services.

☐ If another insurance is primary over Medicare, please inform our staff.

☐ It is <u>your</u> responsibility to inform our staff of insurance policies, updates and changes.

We appreciate your cooperation on these matters – Cedar Run Eye Center Staff

Medicare Policy Holders '10pah



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