Oculoplastic Associates of West Michigan, PLC

MEDICAL HISTORY QUESTIONNAIRE

Today's Date _____

Name _____ **DOB** _____/_____/_____ **Sex M / F**

Reason for your visit today (Please describe the details of your problem): _____

_____

PERSONAL MEDICAL HISTORY:Have you ever had any of the following conditions? Please elaborate where applicable

☐ **NONE**	☐ High Blood Pressure_____	☐ Sleep Apnea _____
☐ Heart Disease _____	☐ Skin Cancer _____	☐ Sinus Disease _____
☐ Bypass / Stents _____	☐ Cancer (type?) _____	☐ Arthritis _____
☐ A-Fib _____	☐ Graves' Disease _____	☐ Hepatitis _____
☐ Stroke _____	☐ Thyroid Disease _____	☐ HIV/AIDS _____
☐ High Cholesterol_____	☐ Diabetes _____	
☐ Other _____		

PERSONAL OCULAR HISTORY: Have you ever had any of the following conditions? Please elaborate where applicable

☐ **NONE**	☐ Retinal Diseases _____	☐ Vision Loss _____
☐ Soft Contacts _____	☐ Thyroid Eye Disease_____	☐ Trauma to Eye _____
☐ Hard Contacts _____	☐ Glaucoma _____	☐ Dry Eyes _____
☐ Other _____		

MEDICATION ALLERGIES (Include type of reaction) ☐ **None** ☐ **See Attached**

_____

_____

_____

SURGERIES (Include approx. date/year) ☐ **None** ☐ **See Attached**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

CURRENT MEDICATIONS (Include dosage along with vitamins, supplements, and over the counter meds)

*****Please remember blood thinners, including aspirin***** ☐ **None** ☐ **See Attached**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

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REVIEW OF HEALTH SYSTEMS: Please indicate any problems you have had in the past 6 months.

☐ **NONE**

CONSTITUTIONAL:

- ☐ Weight gain/loss-more than 10 lbs
- ☐ Marked fatigue
- ☐ Unexplained night fever/sweats

EARS/NOSE/MOUTH/THROAT:

- ☐ Hearing loss or ringing in ears
- ☐ Chronic sinus problems or rhinitis
- ☐ Nose bleeds
- ☐ Dry mouth
- ☐ Difficulty breathing through the nose

CARDIOVASCULAR:

- ☐ Chest pain or angina pectoris
- ☐ Palpitations
- ☐ Shortness of breath with walking
- ☐ Swelling of feet or ankles

MUSCULOSKELETAL:

- ☐ Joint stiffness
- ☐ Weakness in muscles or joints
- ☐ Back or neck pain

HEATOLOGIC/LYMPHATIC:

- ☐ Slow to heal after cuts
- ☐ Bleeding or bruising tendency

RESPIRATORY:

- ☐ Chronic or frequent cough
- ☐ General shortness of breath
- ☐ Asthma or wheezing

ALLERGIC/IMMUNOLOGIC:

- ☐ Atopic disease
- ☐ Dry eye

PSYCHIATRIC:

- ☐ Depression
- ☐ Anxiety

GASTROINTESTINAL:

- ☐ Frequent diarrhea
- ☐ Frequent constipation

INTEGUMENTARY:

- ☐ Rash or itching
- ☐ Sudden change in skin color/hair/nails

NEUROLOGICAL:

- ☐ Lightheadedness or dizziness
- ☐ Numbness or tingling sensation
- ☐ Head injury
- ☐ Migraine headache

CONSTITUTIONAL:

- ☐ Weight gain/loss-more than 10lbs
- ☐ Marked fatigue
- ☐ Unexplained night fever/sweats

FAMILY MEDICAL HISTORY: (Please indicate relation)

Cancer_____ Droopy Eyelids_____

Bleeding Related_____ Anesthesia Complications_____

SOCIAL HISTORY:

Alcohol use? NO YES Smoking? NO YES Drug use? NO YES Live alone? NO YES

Drinks per day _____ Packs per day_____ Type_____

PHARMACY OF CHOICE

_____

Name Address/Crossroads City

PHYSICIAN USE ONLY: _____ Date: _____

Oculoplastic Associates of West Michigan, PLC

PATIENT INFORMATION SHEET

PLEASE PRINT

How did you select our Practice? _____

PERSONAL INFORMATION

Name _____ Date of Birth _____/_____/_____
First Middle Last

Sex: M F Marital Status: S M Sep W D SS#: _____
(Full SSN required for VA patients)

Address _____ City _____ State _____ Zip _____

Phone # Home _____ Work _____ Cell _____ Email _____

Employer _____ Occupation _____

<u>If patient is a minor or has a POA, person responsible for account:</u>

Name _____ Relation _____ DOB ____/____/_____ SS# _____

Address _____ City _____ State _____ Zip _____

Phone # Home _____ Work _____ Cell _____ Email _____

How may we contact you (*please circle all that apply*)? Home / Work / Cell / Email

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Spouse's Name _____ Cell Phone _____

Emergency Contact _____ Relation _____ Phone _____

Information regarding my healthcare may be released/discussed with:
****<u>spouse & emergency contact not automatically included</u>****

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Primary Care Physician _____
Name Address/City Phone

Referring Physician _____
(If other than PCP) Name Address/City Phone

INSURANCE INFORMATION Please bring your insurance card(s) at the time of your appointment.

Primary Insurance _____ Group #_____ Policy # _____

Subscribers Name _____ Date of Birth _____/_____/_____

Secondary Insurance _____ Group #_____ Policy # _____

Subscribers Name _____ Date of Birth _____/_____/_____

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Patient Name _____ DOB _____

MIPS Questionnaire

Please answer the following questions that we, as a provider, are required to report to Medicare each year. Thank you for your help!

Do you currently smoke?	NO	YES
Are you an ex-smoker?	NO	YES
Are you aware of the risks of smoking and the effects it can have on eye disease?	NO	YES
Would you like information regarding quitting smoking?	NO	YES
Have you had your Flu Vaccine this season?	NO	YES
If yes, estimated date or month & year received _____		
Have you had your Pneumonia Vaccine in the last 10 years?	NO	YES
If yes, estimated date or month & year received _____		

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PATIENT AGREEMENT AND AUTHORIZATION
TO RELEASE INFORMATION, FINANCIAL RESPONSIBILITY AND EVALUATION

Insurance Coverage and Payment Responsibility

I, the undersigned, have insurance coverage and assign directly to Oculoplastic Associates of West Michigan, PLC all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage. I understand that I am personally responsible for payment of fees if authorization has not been obtained for whatever reason. I understand that authorization does not guarantee payment by insurance plans. I understand that I am personally responsible for all charges whether or not paid by insurance. I understand that if my account becomes past due and is forwarded to a collection's agency, that a 25% processing fee will be added to my account balance. I authorize Oculoplastic Associates of West Michigan, PLC to release to my insurance carriers any medical information necessary to secure payment of benefits. I permit a copy of this authorization to be used in place of the original.

Diagnostic Testing

I understand that, in addition to the examination, there may be diagnostic tests (visual field test, tear duct system probe and irrigation, CT and MRI scans, labs, etc) and photographs taken as part of my evaluation. These are performed to help in the diagnosis and management of medication conditions. I understand that, as a result, there may be additional out-of-pocket costs, as dictated by my insurance coverage.

Photographs

I understand that it is the standard of care for the Practice to take patient photographs prior to and following the initiation of most clinical treatments and/or the performance of any surgical procedure on patients of the Practice. I hereby **do____/do not____** give my permission for the Practice to use photographs taken of me by the Practice for physician patient education and promotional purposes. Although photographs will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

Eye Dilation

I understand that, as part of my examination, I may be dilated, which involves having drops placed in my eyes. Dilation may cause blurred vision for several hours and make bright lights more bothersome, which vary from person to person. In extremely rare cases, dilation may trigger acute angle-closure glaucoma. I understand that I am to inform the doctor if I do not wish to have my eyes dilated at the time of the examination. Driving and operating machinery afterward is not advised until vision has resumed back to normal.

Medicare Patients

All Medicare patients must sign a lifetime beneficiary claim authorization: I authorize that payment of authorized Medicare benefits be made either to me, or on my behalf, to Oculoplastic Associates of West Michigan, PLC for any services furnished to me by the Practice. 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 to related services. I understand my signature requests that payment be made, and authorizes release of information necessary to pay the claim. If other health insurance is indicated on the electronically submitted claims, my signature authorizes release of information to the insurer or agency shown. In Medicare assigned claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for deductibles, copays, and non-covered services. Co-insurance and the deductible are based on the charge determination of the Medicare carrier.

Signature of Patient/Person Responsible for Account

Date

Oculoplastic
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West Michigan, PLC

CONSENT TO USE OR DISCLOSE INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

Disclose Healthcare for Treatment, Payment, Healthcare Operations

I hereby consent Oculoplastic Associates of West Michigan, PLC to the use of disclosure of my individually identifiable health information in order to carry out treatment, payment, or health care operations. I have the right to review the practice's Notice of Privacy Practices prior to signing their consent form. (Please refer to Oculoplastic Associates of West Michigan, PLC's Notices of Privacy Practices for a more complete description of such uses and disclosures). Oculoplastic Associates of West Michigan, PLC reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. A revised Noticed of Privacy Practices may be obtained by forwarding a written request to Oculoplastic Associates of West Michigan, PLC, 4070 Lake Drive SE, Suite 205, Grand Rapids, MI 49546, or by downloading an electronic version at grandrapidseyelids.com.

Contact via Phone Call, Mail, Email

I hereby consent Oculoplastic Associates of West Michigan, PLC to call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment, or healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care. I consent Oculoplastic Associates of West Michigan, PLC to mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, or health care operations, such as appointment reminders and patient statements. I consent Oculoplastic Associates of West Michigan, PLC to email to my home or other designated location any items that assist the practice in carrying out treatment, payment, or health care operations, such as: appointment reminders and patient statements.

Right to Restrict Disclosure

I have the right to request that Oculoplastic Associates of West Michigan, PLC further restrict how my individual identifiable health information is used or disclosed to carry out treatment, payment, or health care operations. However, Oculoplastic Associates of West Michigan, PLC is not required to agree to such requested restrictions, If Oculoplastic Associates of West Michigan, PLC does agree to my requested restriction(s), such restrictions are then binding.

Right to Revoke Consent

I have the right to revoke this Consent in writing at any time, except to the extent that Oculoplastic Associates of West Michigan, PLC has already taken action in reliance upon prior consent. Oculoplastic Associates of West Michigan, PLC may decline treatment if I do not sign this Consent Form, except to the extent that Oculoplastic Associates of West Michigan, PLC is required by law to treat individuals. If I sign this Consent and then revoke the Consent, Oculoplastic Associates of West Michigan, PLC has the right to decline to provide further treatment to me as of the time of revocation.

I HAVE READ AND UNDERSTAND THIS INFORMATION AND CONSENT TO THE ABOVE STATED TERMS

Signature of Patient/Person Responsible for Account

Date