CASCADE OPHTHALMOLOGY, P.C. 791-A Kenmoor SE, Grand Rapids, MI 49546
Elizabeth H. Henry, M.D., F.A.C.S. Phone: 616-575-8200
Mark O. Moleski, M.D. Fax: 616-954-9622
Sarah K. Hansen, O.D. www.cascadeeyes.com

Today's Date:_______________

Patient's Legal Name: ____ **Birth Date:** ___________ **Age:**________
LAST FIRST MI

Social Security Number:______ - _____ -________ **Email:**______________________________________

Address: ____
STREET CITY STATE ZIP

Home Phone: (____)_______-_______ **Cell Phone:** (____)_______-_________ **Work Phone:** (_____)-______-_________

Employer :____________________________________ **Preferred Contact Method:** *(Please Circle)* Home / Cell / Work

How did you hear about Cascade Ophthalmology: ____

PERSONAL INFORMATION- **Preferred Language:** English/ Other:______________

Please Circle: Married / Single / Divorced / Widowed **Please Circle:** Male / Female

Spouse/ Significant Other's Name: ________________________________ **Phone:** (_____)_____-________

Emergency Contact Person: ______________________________________ **Phone:** (____)_______-_______

Relationship to Patient: ______________________________

INSURANCE INFORMATION-

Who is responsible for this account? ________________________ **Relationship to Patient:**_________________

Primary Insurance:_________________________ **Name of Cardholder:**__________________________

Secondary Insurance:_______________________ **Name of Cardholder:**__________________________

Card Holder's Social Security Number:______-______-________ **Card Holder's Birthdate:**______________

Worker's Compensation: YES____ NO____ **Auto Accident: YES____ NO____**

PHYSICIAN INFORMATION-

Primary Care Physician: ____ (_____)________- ________
NAME ADDRESS PHONE

Referring Physician: ____ (_____)________- ________
NAME ADDRESS PHONE

Optometrist: ____ (_____)________- ________
NAME ADDRESS PHONE

Pharmacy: ____ (_____)________-________
NAME ADDRESS PHONE

PLEASE SEE REVERSE SIDE:

COMPLETE IF PATIENT IS A MINOR OR PATIENT HAS A POWER OF ATTORNEY-

Name of Parent / Legal Guardian / P.O.A.: ____ (____)_________-_______
PHONE

Who is responsible for this account: __________________________________ **Relationship to Patient:**_________________

RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

I hereby authorize my insurance benefits to be paid directly to Cascade Ophthalmology, P.C., realizing that I am responsible to pay non-covered services. I hereby authorize the release of medical information to the insurance carrier and/or employer and their representatives. I also authorize Cascade Ophthalmology, P.C., to release any and all medical information contained within my medical records to referring physicians, consulting physicians, hospitals, laboratories, therapists, pain clinics, or a specifically named location in the course of treatment at Cascade Ophthalmology, P.C. This information may include my physical condition, diagnostic study results, diagnosis, prognosis and/or treatment plan I may also include drug abuse, alcohol abuse, HIV, AIDS, ARC and/or psychological information.

____ ____________________________________

Patient/Legal Guardian Signature Date

REFRACTION FEE

Refraction is a service performed to evaluate whether or not someone is in need of a new eyeglass prescription. It is also needed in order to determine best corrected visual acuity. There are some medical complaints that require doing a refraction as well, such as blurred vision and cataract evaluation. This service is often **NOT A COVERED BENEFIT** with insurance companies and will generate an out of pocket charge to the patient. It is **NEVER** a covered benefit with Medicare. If your insurance does not cover refractions, you will be responsible for the refraction fee, which is $30.00. Please sign below to acknowledge that you have been notified and made aware of this issue.

____ ____________________________________

Patient/Legal Guardian Signature Date

MEDICARE PATIENTS ONLY

LIFETIME SIGNATURE ON FILE

Medicare Number:_____________________________

I hereby authorize that payment of authorized Medicare benefits be made on my behalf, to Cascade Ophthalmology, P.C., for any services furnished to me by a physician of Cascade Ophthalmology, P.C. I authorize any holder of medical information about me, to release to the Center for Medicare and Medicaid Services (HCFA) and its' agents, any information needed to determine these benefits or the benefits payable for related services. I hereby authorize my insurance benefits to be paid directly to Cascade Ophthalmology, P.C., realizing that I am responsible to pay non-covered services. I hereby authorize the medical information to the insurance carrier and their representatives.

- This authorization is in effect until I revoke it.

____ ____________________________________

Patient/Legal Guardian Signature Date

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Patient's Name:______________________________ **Today's Date:** ____________________

Birthdate: ____________ **Age:**____________ **Height:** ____________ **Weight:**______________

Present Problem: ____

How long have you had the problem:____

Do you have any drug allergies? ____

Reactions:____

What Are Your Current Medications?

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Past Ocular History **(Please circle any that apply to your eyes)**

Retinal detachment: R / L Eye Glaucoma Cataract: R / L Eye

Diabetic Retinopathy Laser: R / L Eye-Treatment for:______________

Strabismus Lazy eye: R / L Eye

Macular Degeneration Other________________ Contact Lens Wearer? Y / N

Eye Surgery: Y / N - What Kind? Which Eye?____________________________________

Blindness: Y / N - From what? Which eye?_____________________________________

Past Medical History **(Please circle any of the following conditions you have)**

High Blood Pressure	Neurological problems (explain)	Asthma	Stomach problems (explain)
Emphysema	Heart Disease	Heart Attack	High Cholesterol
Thyroid Problems	Liver Problems	Kidney Problems	Dialysis
Stroke	Vascular Problems	Gastrointestinal	Rheumatoid arthritis

Diabetes Type: 1 2 Cancer-What kind?____________________Did you Undergo: Chemotherapy / Radiation

Other: ____

Past Surgical History **(Please list all past surgeries you have had, including dates if possible)**

______________________ ______________________ ______________________

______________________ ______________________ ______________________

Family History **(Please complete as best as possible)**
HAS ANY FAMILY MEMBER HAD ANY OF THE FOLLOWING PROBLEMS?

Diabetes Who?________________ **Cancer** Who?____________________

Problems with anesthesia Who?________________ **Bleeding** Who?____________________

Eye Problems (see below ▼) Who?________________ **Heart** Who?____________________
(ie: retinal detachment, glaucoma, cataract, lazy eye, macular degeneration, blindness)

PLEASE SEE REVERSE SIDE:

REVIEW OF SYSTEMS: Do you have:

				Social History:
Yes / No	Previous Eye Surgery	Yes / No	Jaundice/Hepatitis	
Yes / No	Contact Lens	Yes / No	Excess Hunger/Thirst	
Yes / No	Pain in Eye(s)	Yes / No	Unintentional Weight Gain	Do you drink alcohol? Yes / No
Yes / No	Double Vision	Yes / No	Pain/Difficulty Urinating	
Yes / No	Glaucoma	Yes / No	Blood in Urine	If yes, how much? ______________
Yes / No	Cataracts	Yes / No	History of Kidney Stones	
Yes / No	Macular Degeneration	Yes / No	History of STD's	Do you currently or have you used
Yes / No	Dry Eyes	Yes / No	Anxiety/Depression	tobacco products? Yes / No / Past
Yes / No	Floaters	Yes / No	Sleep Disorder	
Yes / No	Burning Eyes	Yes / No	Mood Swings	If Yes, how many packs per day?
Yes / No	Watery Eyes	Yes / No	Difficulty Sleeping	
Yes / No	Itchy Eyes	Yes / No	Excess Fatigue	______________________
Yes / No	Hard of Hearing	Yes / No	Easy Bruising	
Yes / No	Ringing in Ears	Yes / No	Gums Bleed Easily	Do/Did you use illicit substances?
Yes / No	Vertigo	Yes / No	Prolonged Bleeding	Yes / No
Yes / No	Sinus Problems	Yes / No	Heavy Aspirin Use	
Yes / No	Sore Throat/Mouth Ulcers	Yes / No	Anemia	If yes, what kind?
Yes / No	Chest Pain	Yes / No	Nose Bleeds	
Yes / No	Dizziness	Yes / No	Muscle Aches	______________________________
Yes / No	Fainting Spells	Yes / No	Arthritis	
Yes / No	Shortness of Breath	Yes / No	Joint Pain/Swelling	Marital Status:
Yes / No	Irregular Heart Beat	Yes / No	Skin Rash/Sores	Married
Yes / No	Difficulty Lying Flat	Yes / No	Skin Lesions	
Yes / No	Swollen Ankles	Yes / No	Hives/Eczema	Single
Yes / No	Nausea/Vomiting	Yes/No	Loss of Hair	
Yes / No	Congestion	Yes / No	Excess Dryness	Widowed
Yes / No	Wheezing	Yes / No	Seizures	
Yes / No	Coughing	Yes / No	Weakness/Paralysis	Divorced
Yes / No	Asthma	Yes / No	Numbness	
Yes / No	Seasonal Allergies	Yes / No	Tremors	Occupation:____________________
Yes / No	Blood Disorders	Yes / No	Headaches	Present or Past
Yes / No	Heartburn	Yes / No	Tingling	

Have you ever or do you currently take **Flomax**? Yes / No

Are there any other medical concerns you would like to discuss with the doctor? Yes / No
If yes? ____

The information provided is accurate to the best of my knowledge.

Signature:____ **Date:** ____________________

Relationship to above patient: **Self** **Parent** **Legal Guardian** **Power of Attorney**

I, (The Doctor), have reviewed the above information with the patient or historian.

Signature: ________________________________ Date: __________

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I____ acknowledge that either:
(Print Name)

☐ **I have received a copy of Cascade Ophthalmology, P.C.'s Notice of Privacy Practices;**

OR

☐ **I declined the offered copy of Cascade Ophthalmology, P.C.'s Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available at www.cascadeeyes.com**

This notice describes how Cascade Ophthalmology, P.C. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

BY CHECKING ANY OF THE BOXES BELOW, YOU CAN AUTHORIZE US TO DISCLOSE INFORMATION (OR RESTRICT ANY SUCH DISCLOSURES). YOU MAY:

☐ **Leave message on answering machine or voicemail**

☐ **Leave information with anyone who answers at my home**

☐ **My health information can be left/discussed with the following individuals:**

Name:____________________________ **Relationship:**______________________

Name:____________________________ **Relationship:**______________________

Name:____________________________ **Relationship:**______________________

☐ **DO NOT give/leave information with anyone other than myself.**

____

(Signature of Patient, or Personal Representative) *(Date)*

____

(Relationship to Patient)