MICHIGAN RETINA CENTER

Asheesh Tewari, MD
Deepak Mangla, MD

Dear Patient:

We would like to welcome you to our practice! In order to expedite your initial visit with us, we are enclosing a new patient packet. Please complete it and bring it along with the items listed below. Please arrive 10 minutes before your scheduled appointment and note that the initial appointment may last up to 2 hours. During the visit, your eyes will be dilated so it may be helpful to have a driver with you.

We look forward to meeting you. Please call us at **(313) 441-2227** if you have any questions.

Please bring:

1. Identification Card (ID)
2. Insurance Card
3. Medication List
4. Insurance Referral (if necessary)
5. Sunglasses

Appointment Information:

Office:

Dearborn
25230 Michigan Ave
Dearborn, MI 48124

(Located on north side of Michigan Ave, between Telegraph and Gulley)

Ann Arbor
Reichert Health Building
5333 McAuley Dr, Ste #1018
Ypsilanti, MI 48197

(On campus of St Joseph Mercy Hospital. Free parking in Lot J)

Day: _____

Date: _____

Time: _____

Location: _____

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Registration Form

Date: _____

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Age: _____ Marital Status: □ Single □ Married □ Other Gender: □ Male □ Female

Home Phone: _____ Cell Phone: _____

Preferred Phone: □ H □ C Email: _____

Occupation: _____ Employer or School: _____

Employer Address: _____

Patient's Language Preference: _____

SNF:	Race:	Ethnicity:
Is patient currently in a Skilled Nursing Facility? □ Yes □ No	□ African American/ Black □ Asian □ Caucasian/White □ Other	□ Hispanic □ Non-Hispanic or Latino

EMERGENCY CONTACT

Emergency Contact Name: _____ Relationship: _____

Emergency Home Phone: _____ Emergency Work Phone: _____

OTHER PROVIDERS

Referring Ophthalmologist/Optometrist: _____ Phone: _____

Address: _____ Fax: _____

Primary Care Physician: _____ Phone: _____

Address: _____ Fax: _____

INSURANCE

Primary Insurance Provider: _____ Policy #: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____ Effective Date: _____

Secondary Insurance Provider: _____ Policy #: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____ Effective Date: _____

INJURY (IF APPLICABLE)

If patient is being seen due to injury, please complete the following:

☐ Injury at work: Date of Injury: _____ Claim #: _____

Case Worker/Adjuster Name: _____ Phone: _____

☐ Auto Accident: Date of Accident: _____ Claim #: _____

Case Worker/Adjuster Name: _____ Phone: _____

PATIENT OR AUTHORIZED PERSON SIGNATURE

I certify the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to Michigan Retina Center. I acknowledge I am responsible for payment if my insurance company denies my claim.

X _____

Patient or Authorized Person Signature

_____

Date

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NEW PATIENT HISTORY

Today's date: _____

Name: _____ Date of Birth: _____

CHIEF COMPLAINT: Main reason for today's visit?

Symptoms: _____ **Eye:** □ *Right* □ *Left* □ *Both*

Severity: □ *Mild* □ *Moderate* □ *Severe* **Onset:** □ *Sudden* □ *Gradual*

Duration: _____ *hours/days/weeks/months/years* **Timing:** □ *AM* □ *PM* □ *Positional*: _____

Context: □ *Reading* □ *Watching TV* □ *Other:* _____

Modifying (what makes it better or worse?): _____

_____

MEDICATIONS: Do you take *Aspirin, Plavix, Coumadin, or Eliquis*? (Please circle) □ *Yes* □ *No.*

Do you take *Metformin, Glipizide, Glimepiride, Novolog, or Humalog*? (Please circle) □ *Yes* □ *No.*

Eye-related Medications	General Medications

Allergies to drugs/ medications: □ *Yes* □ *No*. If yes, which? _____

PAST MEDICAL HISTORY:

What medical diagnoses have you had, including but not limited to the following?

1. Sugar Diabetes: □ *Yes* □ *No.* If yes, last blood sugar? _____ mg/dL. When? _____

   Last HbA1c? _____ When? _____ On Insulin? □ *Y* □ *N.*

2. High Blood Pressure: □ *Yes* □ *No.* If yes, taking which meds? _____
3. Rheumatoid Arthritis: □ *Yes* □ *No.* If yes, taking Plaquenil? □ *Yes* □ *No.*
4. Kidney Disease: □ *Yes* □ *No.* If yes – on dialysis? □ *Yes* □ *No.* Which days? _____
5. Other Medical Diagnoses: _____

Have you ever had any *major surgery*? □ *Yes* □ *No.* If yes, specify: _____

_____

Have you ever had any *eye surgery* or *laser treatment*? □ *Yes* □ *No.*

If yes, specify: _____

Which eye? □ Right □ Left □ Both When? _____

FAMILY HISTORY: Do you or an immediate family member have: If yes, please specify who?

Retinal Detachment	□ *Yes* □ *No*	_____
Glaucoma	□ *Yes* □ *No*	_____
Macular Degeneration	□ *Yes* □ *No*	_____
Blindness	□ *Yes* □ *No*	_____
Diabetes	□ *Yes* □ *No*	_____
Other	□ *Yes* □ *No*	_____

SOCIAL HISTORY:

Have you ever smoked tobacco? □ *No* □ *Yes – if so, how often*? _____

How often do you drink alcohol? □ *Never* □ *Occasionally/ Socially* □ *Multiple drinks per day* Do you use recreational drugs? □ *No* □ *Yes – if so, how often*? _____

Do you work? □ *No* □ *Yes*: _____

REVIEW OF SYSTEMS	*Yes*	*No*	*Specify*	*When diagnosed?*
Endocrine problems? (Diabetes, Pancreas, Thyroid)	□	□		
High Blood Pressure?	□	□		
Heart problems? (Heart attack or disease, Stroke)	□	□		
Pacemaker or Defibrillator?	□	□		
Cancer or Blood disorders?	□	□		
Respiratory/ Breathing problems? (Asthma, Emphysema, Lung Disease)	□	□		
Neurologic problems? (Numbness, Seizures, Paralysis)	□	□		
Muscle or Joint problems? (Arthritis)	□	□		
AIDS / HIV?	□	□		
Other problems?	□	□		

PHARMACY: Name: _____

Phone Number: _____ Location: _____

_____ _____

Patient Signature Date

_____ _____

History Reviewed: Physician Signature Date