



DR. JEFFREY ZIGULIS
DR. MEGAN BROOKS
 OPTOMETRISTS

ADVANCED EYE CARE • 7470 SECOR ROAD • LAMBERTVILLE, MI
 ADVANCED EYE CARE • 228 TECUMSEH ST • DUNDEE, MI
 ADVANCED EYE CARE • 1073 PRAY BLVD • WATERVILLE, OH

Welcome To Our Office

Name _____	Today's Date _____
DOB _____ / _____ / _____	Date of Last Eye Exam _____
Address _____	Parent or Guardian _____
City _____ State _____ Zip _____	Employer _____
Home Phone _____	Occupation _____
Cell Phone _____	Hobbies _____
Social Security Number _____ - _____ - _____	*Email _____

**for using our patient portal services*

<p>Insurance Information (must be completed to file any claims)</p> <p>Name of Policy Holder _____</p> <p>Policy Holder DOB _____ / _____ / _____</p> <p>Medical Ins _____</p> <p>Vision Ins _____</p> <p>Insurance ID# _____</p> <p>Insurance Group# _____</p> <p>Patient Relationship to Insured _____</p> <p>Patient Current Marital Status _____</p>	<p>Please indicate your ethnicity:</p> <p><input type="checkbox"/> African American <input type="checkbox"/> Native American</p> <p><input type="checkbox"/> Asian <input type="checkbox"/> I prefer not to answer</p> <p><input type="checkbox"/> Caucasian <input type="checkbox"/> Other</p> <p><input type="checkbox"/> Hispanic/ Latino</p> <p>EMERGENCY CONTACT:</p> <p>Name _____</p> <p>Relation _____</p> <p>Phone _____</p>
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Your Release of Health Care Information

I hereby authorize Advanced Eye Care (doctor and staff) to release, disclose, and discuss my medical information to the following persons:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Please check here if you **DO NOT WANT** your health care information discussed with anyone other than yourself.

Optomap Retinal Photos: Ultra-wide Digital Retinal Exam

The Optomap Digital Retinal Exam is a fast, easy and comfortable procedure. It provides a permanent record to track and compare potential eye diseases. It also gives an in-depth view of nearly the entire retina to be used as an educational tool for your doctor to determine the health and wellness of your eye. Please note, this digital retinal exam may include dialation. In most cases, patients do not need to be dilated for this exam, but it still may occur.

If you wish to decline this procedure: By signing below, I understand that a widefield view of the retina is an important part of a comprehensive eye exam and I am declining the Doctor's recommendation to obtain a comprehensive veiw of my retina. I understand that since I am declining, I may have to be dilated in order for the doctor to obtain a complete view of my retina.

Signature or Authorized Party: _____ Date: _____

Consent & Authorization to Release Information

I hereby authorize treatment and the release of any information or photographs acquired in the course of my examination or treatment to my referring doctor, medical professional, or insurance company as necessary. I understand that I am financially responsible for services and materials provided to me at Advanced Eye Care, the offices of Zigulis Eye Care, Inc.

Signature or Authorized Party: _____ Date: _____



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Medical / Social History

Name _____
 DOB _____ / _____ / _____
 Last Blood Pressure Reading (Or Average) _____ / _____

Height _____
 Weight _____
 Sex: Male Female

Personal Medical History
 Please indicate if you have any of the following:

Allergy to Meds	Y/N	Eye Disorders	Y/N
Arthritis	Y/N	Fibromyalgia	Y/N
Asthma	Y/N	Heart Disease	Y/N
Cancer	Y/N	High Blood Pressure	Y/N
Depression	Y/N	Migraines	Y/N
Digestive Disorder	Y/N	Neurological Disorder	Y/N
Diabetes	Y/N	Skin Disorder	Y/N

Current Medications

Please list any Rx or over the counter meds:

Name of Medication	Reason for Taking
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_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Name of family doctor: _____

List all meds you are allergic to: _____

Family Medical History

Please indicate if any of your family members have had the following:

Diabetes	Y/N	Blindness	Y/N	High Blood Pressure	Y/N	Retinal Detachment	Y/N
Glaucoma	Y/N	Cataracts	Y/N	Macular Degeneration	Y/N		

Who in your family has these diagnoses? _____

Do you drink alcohol?	Y/N	If yes, type/amount/how long	_____
Do you use illegal drugs?	Y/N	If yes, type/amount/how long	_____
Do you currently use tobacco products?	Y/N	If yes, type/amount/how long	_____
Previously used tobacco products?	Y/N	If female, are you currently pregnant?	Y/N
Ever been exposed to or infected with:	<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Syphilis <input type="checkbox"/> Other		

Please list any past EYE RELATED surgeries:

Type of Surgery	Surgeon's Name	Date/Year
_____	_____	_____
_____	_____	_____
_____	_____	_____

How Did You Hear About Our Office?

Friend or Relative - Who? _____
 A Healthcare Professional - Who? _____
 Insurance List? _____

1. Copays are due at the time of services. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I authorize the release of any medical information necessary to process my claim. I agree to pay for services and/or supplies that are denied by my insurance company. **I understand that if there is a medical diagnosis, my medical insurance, not my vision insurance, will be billed.** This includes, but is not limited to: diabetes, cataracts, glaucoma, dry eye, or any other medical diagnosis. I understand that I will be responsible for any deductible or copays that remain after insurance claims have been reviewed or processed.

2. Release of Information: All records concerning the patient's treatment remain the property of Advanced Eye Care, though the patient may obtain a copy by making a written request. As a condition of the patient receiving care at Advanced Eye Care, the undersigned consents to the use and disclosure of health information about the patient, including: other health care providers (i) in order to carry out that care and treatment of the patient, (ii) to the extent necessary to determine liability for payment and to obtain reimbursements/ authorization, and (iii) for Advanced Eye Care internal health care operations such as quality improvement, risk management, credentialing, peer review business management, etc.

3. Medicare/Insurance Benefits: I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I request the payment of authorized Medicare benefits. I authorize a holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration, its intermediaries, or carriers of any information needed for this or a related Medicare claim. I understand that Medicare will pay only for services which they determine to be reasonable and necessary under Section 1862(a)(1) of the Medicare Law. If Medicare denies payment for some or all of these services, I agree to pay for them.

Signature or Authorized Party: _____

Date: _____