

Patient Demographics

Account Number: _____

Today's Balance: \$ _____

Past Due Balance: \$ _____

Total Due Today: \$ _____

First Name: _____ Last Name: _____

Date of Birth: _____ SSN: _____ Previous Name: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Email: _____ Gender: _____

Preferred Phone

Home _____ Cell: _____ Work: _____

Additional Info

Marital Status:	Language:	Race:	Ethnicity:
<input type="checkbox"/> Married	<input type="checkbox"/> English	<input type="checkbox"/> Alaska Native	<input type="checkbox"/> American Indian
<input type="checkbox"/> Single	<input type="checkbox"/> Spanish	<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic / Latino
<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Arabic	<input type="checkbox"/> Black / African American	<input type="checkbox"/> Not Hispanic / Latino
<input type="checkbox"/> Widowed	<input type="checkbox"/> Mandarin	<input type="checkbox"/> Native Hawaiian / Pacific Islander	<input type="checkbox"/> Decline
<input type="checkbox"/> Divorced	<input type="checkbox"/> Other	<input type="checkbox"/> Decline	

Doctor Information

Referring Doctor: _____ Phone: _____ Fax: _____

Address: _____ City: _____ Zip: _____

Primary Care Doctor: _____ Phone: _____ Fax: _____

Address: _____ City: _____ Zip: _____

Specialist: _____ Phone: _____ Fax: _____

Address: _____ City: _____ Zip: _____

Contacts

Authorized Contact: In order to share any legally protected information about your healthcare, appointments, or medical data with anyone other than yourself, please provide their name, phone number, and relationship to you below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I authorize Midwest Vision Partners to release health information identifying me to the person(s) listed above.

Signature: _____ Date: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Dilation Consent

INFORMATION REGARDING DILATING EYE DROP

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize my doctor and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose and treat my condition. I understand that, with rare exception, dilation is done on every visit at Retina Consultants of Michigan.

Patient (or person authorized to sign for patient)

Date

Witness

Date

Acknowledgement of Notification of Patient's Rights to Privacy

I acknowledge that I have been notified of Midwest Vision Partners' Notification of Patient's Rights to Privacy.

Signature: _____ Date: _____