# Scarbrough Family Eyecare Scarbrough Professional Services, P.C.

527 West Front Street Traverse City, Michigan 49684 (231) 947-8667 1144 Beulah Hwy Beulah, MI 49617 231-882-5542

www.ScarbroughFamilyEyecare.com

## **Patient Registration**

Date:\_\_\_\_\_

Please revie	w, mak	e necessa	ry change	es and sup	ply any mis	ssing info	ormation.
Patient Name:				-	Nickname:		
Date of Birth:		Age:			Marital Status	s:	
Sex:					SS#		
Mailing Address:							
City:				State:		Zip Code:	
•			Commi	unication		-	
Home Phone #			Work	Phone #		Exte	ension:
Cell Phone #			"			,	
EMAIL:							
Your email address is u	sed to ser	nd the results	of your exa	n to you and f	or recall purpo	ses.	Declined:
			Infor	mation			
Spani: Frend	shshshshser		Black o	ian or Alaska N A or African Amer iian/Pacific Isla	sian ican inder /hite	Not His Hispa	(check one): panic or Latino anic or Latino ne to specify
Occupation:			Employer:			"	
			Account F	Responsible			
Responsible:							
Relationship:					SS#		
Mailing Address:							
City:				State:		Zip Code	<b>)</b> :
Home Phone #			Work Phone	#		Extension:	
			Emergen	cy Contact			
First:	Last:			Relation:	Home #	Cell#	Work #
		NEW PATIEN	NTS ONLY - H	low did you he	ar about us?		
Friend or Family?				Travei	rse Magazine _	Goog	le Reviews
Facebook Websit	te	Insurance _	Other_				

## **Patient Health History**

Please review, make necessary changes and supply any missing information.

Patient Name:		Date of Birth:
Primary Care Physician:	Reason for Last Visit:	Approximately when was your last visit:
New Patients only:		New Patients only:
Last Eye Doctor:		Date of last eye exam: Dilated: Yes No
	Medical Histo	ory
Plea	se list any <i>CURRENT</i> illnesses,	symptoms or problems:
Heart / Blood Pressure	Ne	rves / Brain
Ears, Nose, Throat	Psy	ychiatric
Breathing	Kid	Ineys / Thyroid
Stomach	Blo	ood
Urinary / Reproductive	Alle	ergies (not medications)
Bones / Joints / Muscles	Dia	betes
Skin	Hea	adaches
Other		
Do you work on a computer?		Hours per day:
Placed Occupants of Article 179 11	Diabetic Inform	
Blood Sugar test: Value/Reading	g: A1c	test : Value/Reading:
	Eye Surgery Infor	mation
Procedure:	E	ye:
		·
		·
	B. 44B. 45	
<b></b>	Past / Present Eye	•
Please lis	t any past or present EYE illne	<u> </u>
	Self:	Family:
Glaucoma		
Cataracts		
Macular Degeneration		
Eye Injury		
Retinal Disease		
Other Disease		
Blindness		
Lazy Eye		
Diabetes		
Dry Eye		
Refractive		

	Social I	History	
	oker or never smoked? veryday or some days?		
Occupation:			
	Lifestyle In	formation:	
Please circle any of the follow	ring that pertain to you:		
Drive a lot at night Work of	outside in the sun Hazard	ous job; construction, etc. Walking; F	Running; Biking
Read for work/Pleasure Sho	oting sports; hunting, etc. Wa	ter sports; fishing, etc. Team sports	s; baseball etc.
Other special vision needs:			
	Migra	inge	
Daniel Minnelson	_		
Do you suffer from Migraines	? It so, now often do you expe	rience them?	
	Current Mo	adiantiona	
	(OR WE CAN COPY YO		
	ions that you are no longer tal ver the counter and herbal me		
Date Name	Strength	Directions	
	Are you allergic to any medi	cations,? If yes, please list:	
	Contact Le	ns History	
Type of contact lenses you		How often do you replace your	
<b>currently use</b> (gas permeable, soft daily, extended)		contacts? (daily, weekly, monthly)	
Average number of hours	Number of hours	Wearing Type (daily,	
that you wear your contacts	worn today	weekly, 2 weeks, monthly, extended)	
ı	ı l	1	
	Pupil D	ilation:	
effects of pupil dilation can last		ary for the doctor to dilate your pupils wunlight sensitivity and possible blurred variety.	
If found necessary, I prefer to be			Prefer not to be dilate

#### Scarbrough Family Eyecare Scarbrough Professional Services, P.C. 1144 Beulah Highway Beulah, Michigan 49617 (231) 882-5542

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### **Acknowledgement Of Privacy Practices**

I agree to the use and disclosure of my protected health information by Scarbrough Family Eyecare for the purpose of diagnosing, providing treatment to me, or obtaining payment for my health care bills and to conduct health care operations of Scarbrough Family Eyecare.

I request that payment of my insurance benefits or Medicare be made either to me or on my behalf to Scarbrough Family Eyecare for any services rendered to me.

I will allow you to file directly to my insurance carrier(s) for me, and I accept responsibility for obtaining necessary insurance forms if my insurance company requires its own form.

I understand I am financially responsible for any amount not covered by my insurance contracts or Medicare. This includes deductible, co-pays, and non-covered services.

#### I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES.

I have the right to revoke this consent, in writing, at any time, unless they have already treated me, sought payment for their services, or performed health care operations in reliance upon their ability to use or disclose my health information in accordance with this consent. I understand that this office can decline to serve me if I choose not to sign this form.

Scarbrough Family Eyecare's Notice of Privacy Practices describes your rights and the duties of this office with respect to your protected health information. Please refer to this notice posted in the lobby or ask for a copy.

I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices from Scarbrough Family Eyecare.

Signature of Patient		Date
•	epresentative & Relationship a minor or an adult unable to sign form)	Date
The following	individuals have my authorization to	access my Protected Health Information
The following	individuals have my authorization to  Relationship	Date of Birth

**Emergency Contact** 

First:

Last:

Relation:

Home #

Cell#

Revised: 7/17/2025

Work #