GUEST • MALACH
EYE SPECIALISTS

21931 East 9 Mile Road
St. Clair Shores, MI 48080
586-210-2464 | guestmalacheye.com

NEW PATIENT REGISTRATION

Full legal name

Date of birth

Preferred name

Sex ○ M ○ F

Spouse's name (if applicable)

Street address and apartment/unit

City

State

ZIP code

Cell phone

Alternate phone

Email address

Preferred language

Do you need an interpreter or help completing forms? ○ Yes ○ No

Accessibility or assistance needs (for example, hearing, vision, mobility)

Emergency contact

Name and relationship

Phone

An emergency contact is not automatically authorized to receive your medical information. List your preferences on page 6.

Your care team

Primary care physician

Phone

Referring provider or how you heard about us

Family history (other than yourself)

	Grandparent	Parent	Sibling	Unknown
Glaucoma	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐
Blindness	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Cancer	☐	☐	☐	☐

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Insurance and eye history

Enter your medical insurance information below. Do not provide a Social Security number.

Insurance coverage

Primary medical insurance

Member ID / group number

Subscriber name and date of birth

Relationship to patient

Secondary medical insurance (or none)

Member ID / group number

Subscriber name and date of birth

Relationship to patient

Reason for your visit

Main concern, which eye, and when it started

Is this visit related to an auto accident? ○ Yes ○ No

Is this visit related to a work-related injury? ○ Yes ○ No

Eye conditions (Check all that apply)

- ☐ None
- ☐ Amblyopia (weak eye from childhood)
- ☐ Aphakia
- ☐ Astigmatism
- ☐ Blepharitis
- ☐ Cataracts
- ☐ Color Blind
- ☐ Contact Lens Wear
- ☐ Crossed/lazy eye
- ☐ Diabetic Retinopathy
- ☐ Dry Eye
- ☐ Eye Allergies
- ☐ Eye Trauma
- ☐ Glaucoma
- ☐ Glaucoma Suspect/Ocular Hypertension
- ☐ Herpes Eye Infection
- ☐ Hyperopia (Farsighted)
- ☐ Iritis
- ☐ Keratoconus
- ☐ Macular Degeneration
- ☐ Myopia (Nearsighted)
- ☐ Optic Neuritis
- ☐ Retinal Tear/Detachment
- ☐ Shingles Eye Infection
- ☐ Sjogren's
- ☐ Thyroid Eye Disease

Other conditions or details, including which eye

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Eye procedures and medications

Check each previous procedure and select Right, Left, or Both for the eye treated.

Previous eye procedures

☐ None		☐ Blepharoplasty	Select
☐ Cataract Surgery	Select	☐ CK	Select
☐ Cornea Transplant	Select	☐ Foreign Body Removal	Select
☐ Glaucoma Laser (SLT)	Select	☐ Narrow Angle Laser (Yag LPI)	Select
☐ Glaucoma Stent or Surgery	Select	☐ LASIK, PRK or SMILE	Select
☐ Punctal Plugs	Select	☐ RK	Select
☐ Strabismus/muscle Surgery	Select	☐ Scleral Buckle	Select
☐ Retinal Tear/Detachment	Select	☐ Retina Injection	Select
☐ Retina Laser Procedure	Select	☐ Vitrectomy	Select
☐ Yag Capsulotomy	Select		

Past eye surgeries not listed above

Current eye drops

☐ No eye drops

Eye drop name	Eye	How often

Previous eye care

Previous eye doctor

Date of last eye exam

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Medications and allergies

Allergies

☐ No known medication allergies ☐ Allergies listed below ☐ Not sure

Medication / latex / adhesive / other	Reaction

Current prescription medications, infusions, vitamins and supplements

☐ None

Medication and strength	Dose / how often

Preferred pharmacies

Local pharmacy name and street / city

Phone (if known)

Mail pharmacy name (if applicable)

Phone (if known)

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Health history

Check all that apply. Your care team will review your answers with you.

Medical conditions

- [ ] Overall healthy
- [ ] Anxiety
- [ ] Atrial Fibrillation or heart arrhythmia
- [ ] Congestive Heart Failure
- [ ] Coronary Artery Disease
- [ ] Diabetes A1c _____
- [ ] Fibromyalgia
- [ ] Hepatitis A/B/C
- [ ] High Blood Pressure/Hypertension
- [ ] HIV
- [ ] Kidney Disease
- [ ] Lung Disease
- [ ] Migraine
- [ ] Parkinson's
- [ ] Rheumatoid Arthritis
- [ ] Stroke
- [ ] Alzheimer's
- [ ] Asthma
- [ ] Bleeding disorder
- [ ] Connective Tissue Disease
- [ ] Dementia
- [ ] Pre-diabetes/borderline diabetes
- [ ] Headaches
- [ ] Herpes Simplex
- [ ] High Cholesterol
- [ ] Hyperthyroidism
- [ ] Kidney Stones
- [ ] Lupus
- [ ] MRSA
- [ ] Polymyalgia Rheumatica (PMR)
- [ ] Sarcoidosis
- [ ] Syphillis
- [ ] Anemia
- [ ] Arthritis
- [ ] Cancer
- [ ] COPD/Emphysema
- [ ] Depression
- [ ] Eczema
- [ ] Hearing Loss
- [ ] Herpes Zoster/Shingles
- [ ] Histoplasmosis
- [ ] Hypothyroidism
- [ ] Liver Disease
- [ ] Meningitis
- [ ] Multiple Sclerosis
- [ ] Psychiatric Disorder
- [ ] Skin cancer
- [ ] Toxoplasmosis

Systemic conditions not listed above

Non-eye surgeries, major hospitalizations, and approximate dates (or none)

Select your smoking history

- ○ Current every day smoker
- ○ Current some day smoker
- ○ Former smoker
- ○ Never smoker

Amount smoked / quit year (if applicable)

How often do you consume alcohol?

- ○ Daily
- ○ Weekly
- ○ Monthly
- ○ Occasionally
- ○ Never

Amount consumed / other substance use (if applicable)

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Communication and privacy choices

Your choices below are optional and do not affect your access to care.

How we may contact you

May we leave a detailed voicemail at your preferred number? ○ Yes ○ No

May we text appointment reminders and office or billing messages? ○ Yes ○ No

May we email appointment reminders and office or billing messages? ○ Yes ○ No

We use your contact details on page 1 unless you give other instructions. Text and email may be unencrypted. Frequency varies; message/data rates may apply. Reply STOP to stop texts; reply HELP or call us for help. We do not share SMS consent or mobile opt-in information for third-party marketing. These choices do not authorize marketing. Call us to request another contact method. Do not use messaging for emergencies.

People involved in your care (Optional)

I permit discussions relevant to my care or payment with the people below, subject to my written limits. This does not authorize my complete record or appoint a legal decision maker. I may change or withdraw permission by contacting the office.

Name	Relationship	Phone

☐ I am not naming anyone at this time

Limits on discussions / prescription pickup permissions (optional)

Patient or personal representative signature

Date

If representative signs: printed name and legal authority (parent, guardian, healthcare agent)

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Insurance and financial policy

Please review this policy and contact our office with questions before signing.

Medical insurance and coverage

Our services are billed under medical insurance. We do not accept vision insurance. Please provide current insurance information, report coverage changes, and bring your insurance cards and photo ID to each visit. Check with your plan about benefits, network participation, deductibles, copayments, and coinsurance. We submit claims to plans we bill, but benefit verification does not guarantee payment.

HMO referrals and prior authorization

Many HMOs and some other plans require a referral from your assigned primary care physician (PCP) before specialist visits. Requirements vary by plan. If required, please contact your PCP before your appointment and confirm that our office has received a valid referral covering the visit. A recommendation from another specialist may not satisfy your plan's PCP referral requirement. Tell us if you need help.

A referral and prior authorization are different. Our office obtains authorizations when required by our payer agreements. A referral or authorization does not guarantee that every service is covered or paid in full. If required documents are missing, a nonurgent visit may need to be rescheduled. Any patient charges remain subject to law, payer contracts, and required notices.

Your financial responsibility

Copayments, deductibles, coinsurance, and other permitted patient charges are due at the time of service unless we agree to another payment arrangement. Insurance may not cover every service or pay the full allowed amount. You are responsible only for amounts we may legally collect from you; you are not responsible for contractual write-offs or prohibited charges. Contact us promptly about billing questions or difficulty paying. We can help clarify claims and coverage questions; your plan makes benefit determinations.

Noncovered and elective services. We will explain anticipated patient charges before these services. Refraction (testing for an eyeglass prescription) is separate from the medical examination and is generally not covered by Original Medicare or commercial insurance plans. Optional cataract lens upgrades and elective services require a separate fee discussion. This policy does not replace a required Medicare Advance Beneficiary Notice or other service-specific notice.

Payment methods and fees. We accept cash, checks, debit/credit cards, HSA/FSA payments, and ACH. Personal checks returned for insufficient funds incur a $25 processing fee, subject to applicable law; we may then require another payment method for future transactions. Any credit card surcharge will be disclosed before payment and charged only as permitted by law, card-network rules, and insurance contracts.

Appointments. Notify us as early as possible if you need to cancel or reschedule. Any applicable missed-appointment or late-cancellation fee will be disclosed under our office policy before it is charged.

Acknowledgment and assignment of benefits

I have reviewed this policy and agree to pay permitted patient charges. I assign applicable insurance benefits to Guest Malach Eye Specialists and authorize payment of those benefits directly to the practice. Insurance billing disclosures are described in the Notice of Privacy Practices.

Patient or personal representative signature

Date

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Consent and acknowledgments

Please read each section and sign separately. Ask our staff if you have questions before signing.

Consent for examination and care

I consent to examination and diagnostic care, including vision testing, pressure measurement, imaging, and appropriate eye drops. Staff will explain recommended dilation, which may cause temporary blur and light sensitivity. I will avoid driving until vision is clear and arrange a driver if needed. I may ask questions or decline care. Surgery, lasers, injections, and other procedures requiring specific informed consent need separate discussion and consent. No outcome is guaranteed.

Patient or personal representative signature

Date

Receipt of the Notice of Privacy Practices

I acknowledge receipt of the Guest Malach Eye Specialists Notice of Privacy Practices provided separately. I may request a paper copy. My signature acknowledges receipt; it is not a blanket authorization to disclose information or a waiver of my rights.

Patient or personal representative signature

Date

If signing as a representative, complete your name and authority on page 6.

Staff use: If acknowledgment is not obtained, document the attempt, date, and reason.