First Name: ___________________________ M.I: ________ Last Name: _____________________________ SS#: ___________________________

□ Male □ Female Birthdate: _________________ Age: ______ Marital Status: □ Single □ Married □ Divorced □ Other

Mailing Address: ____ City: _____________________________ State: ______ Zip: _________________

E-mail Address: ____ Primary Care Physician: ______________________________________

Please check your preferred contact number. □ Home Phone: ____________________ Preferred Pharmacy: ____

□ Work Phone: ____________________ Employer: ____

□ Mobile Phone: ___________________ Preferred Language: □ English □ Spanish □ Other ______________

Do you consider yourself to be of Hispanic or Latino origin? □ Yes □ No □ Prefer not to answer

Which of the following best describes your **race**?

□ American Indian /Alaska Native □ Asian □ Native Hawaiian /Pacific Islander
□ Black / African American □ White □ Prefer not to answer

Please provide us with your health information by filling out the following as accurately as possible:

Allergic/Immunologic □ Drug Allergy □ Environmental Allergy □ Rheumatoid Arthritis □ Lupus □ Other ______________________ □ None	**Eyes** □ Glaucoma □ Cataracts □ Macular Degeneration □ Surgery □ Blurred Vision □ Inflammatory Disorder □ Double Vision □ Other ______________________ □ None	**Musculoskeletal** □ Fibromyalgia □ Muscular Dystrophy □ Osteoarthritis □ Ankylosing Spondylitis □ Other ______________________ □ None	**Cardiovascular** □ Heart Disease □ High Blood Pressure □ Stroke □ Vascular Disease □ Elevated Cholesterol □ Other ______________________ □ None
Gastrointestinal □ Crohn's □ Colitis □ Ulcer □ Digestive □ Other ______________________ □ None	**Neurological** □ Multiple Sclerosis □ Epilepsy □ Alzheimer's □ Parkinson's □ Cerebrovascular □ Other ______________________ □ None	**Constitutional** □ Developmental Disability □ Weight Loss □ Fever □ Fatigue □ Trauma □ Other ______________________ □ None	**Genitourinary** □ STD, Herpes, Chlamydia □ Other ______________________ □ None
Psychiatric □ Depression □ Panic Disorder □ Schizophrenia □ Other ______________________ □ None	**Ear/Nose/Mouth/Throat** □ Respiratory Tract Infection □ Ear Ache □ Runny Nose □ Sore Throat □ Ringing / Tinnitus □ Other ______________________ □ None	**Blood/Lymphatic** □ Anemia □ Large Volume Blood Loss □ Leukemia □ Other ______________________ □ None	**Respiratory** □ Current Tobacco User □ Previous Tobacco User □ Asthma □ Bronchitis □ Emphysema □ Other ______________________ □ None
Endocrine □ Non-insulin dependent diabetes □ Insulin-dependent diabetes □ Thyroid dysfunction □ Hormonal dysfunction □ Other ______________________ □ None	**Other** □ Currently pregnant □ Currently nursing □ Other ______________________ □ None	**Height** _____________ **Weight** _____________ **A1C** if applicable ___________	

Please check if you have a family history of any of the following:
□ Blindness □ Cataracts □ Glaucoma □ Macular Degeneration □ Lazy Eye □ High Blood Pressure □ Stroke □ Diabetes

List your medication allergies: ____

List your medications with dosage (or provide a list for scanning): ____

____

Medical Insurance ______________________________ Cardholder's Name ___________________________ Cardholder's D.O.B. ________________

Vision Insurance _______________________________ Cardholder's Name ___________________________ Cardholder's D.O.B. ________________

Certification and Assignment

I hereby authorize Drs. Gundersen and Zuker to diagnose and treat my condition as deemed medically necessary. To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, have a change in health.

If Drs. Gundersen and Zuker choose to accept assignment of my insurance benefits, I hereby assign to Drs, Gundersen and Zuker all money to which I am entitled for eye care expenses relative to the service reported, but not to exceed my indebtedness to Drs. Gundersen and Zuker. I understand that I am financially responsible to Drs. Gundersen and Zuker for all charges, regardless of insurance benefits.

X____ ____________________________________

Signature of Patient, Parent, Guardian, or Personal Representative *Date*

____ _____________________________________

Print Name of Patient, Parent, Guardian, or Personal Representative *Relationship to Patient*

Receipt of Notice of Privacy Policies and Consent Form

Drs. Gundersen and Zuker

442 W. Western Ave.
Muskegon, MI 49440
(231)722-3556
Fax (231)726-6334

1030 S. Mears Ave.
Whitehall, MI 49461
(231)893-5671
Fax (231)893-7585

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services and to conduct health care operations involving our office.

The ***Notice of Privacy Practices*** you have access to describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our ***Notice of Privacy Practices***, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third-party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third-party payers and insurers; and (4) other aspects of payment described in our ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** will be updated whenever our privacy practices change. You can get an updated copy here at the office or from our website.

When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment for our services and to perform health care operations, As described in our ***Notice of Privacy Practices***, you have the right to request a restriction to your personal health information, however, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

EMERGENCY CONTACT:

Name___________________________________ Relationship_____________________________ Phone_________________________

Permitted Use of Protected Health Information (in addition to EMERGENCY CONTACT above):

Please list family members or friends to whom we may disclose your personal health information in regard to health care and billing. For parents or legal guardians, please include any adults who may bring the patient to us in your absence.

Name ____________________________________ Relationship ____________________________ Phone _________________________

Name ____________________________________ Relationship ____________________________ Phone _________________________

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations, I acknowledge that I have received the *Notice of Privacy Practices* for the office of Drs. Gundersen and Zuker. I agree to all of the above uses disclosures and understand that this will remain in effect until I notify Dr. Gundersen and Zuker of any changes.

Signature X____ Date __________________________________

**If signing as a personal representative of the patient, describe the relationship to the patient and the source of authority to sign this form.

Name _____________________________________ Relationship to Patient __________________________ Source of Authority ________________