



GRAND RAPIDS OPHTHALMOLOGY

Eye Care | Surgery | Laser Correction

Ophthalmologists

Gilbert Vanderveen, MD
Kenyon Kendall, DO
Scott Weber, MD
David Barrett, MD
Thomas Cowden, MD
Yosef Gindzin, MD
Marcus Muallem, MD
Michael Boyle, MD
Robert Roosenberg, MD
Mark Sheldon, MD
Laura Piippo, MD
Michael Crawford, MD
Larry Gerbens, MD*
Gerard vanWesep, MD*

Optometrists

Thomas Dunning, OD
Gerard Choryan, OD
Jay Crank, OD
Philip VanderLugt, OD
Charlene Hamilton, OD
Gregory Patera, OD
David Den Braber, OD
Monica Fenton, OD
Rachel Hollenbeck, OD
Brian Dolphin, OD
Lindsay Basler, OD

Clinical Specialists

Patti Lacy, CO
Tim Durham, FCLSA

*Emeritus

East Beltline

750 East Beltline, N.E.
Grand Rapids, MI 49525
616.949.2600
(f) 616.949.1670

Walker

3300 Walker View Dr.
Walker, MI 49544
616.949.2600
(f) 616.588.6516

Grandville

4475 Wilson, S.W.
Grandville, MI 49418
616.949.2600
(f) 616.588.6547

68th Street

Spectrum South
80 68th St., S.E.
Grand Rapids, MI 49548
616.949.2600
(f) 616.588.6519

Ionia

537 W. Main Street
Ionia, MI 48846
616.527.1640
(f) 616.527.3756

Holland

Lakeshore Medical Campus
3235 N. Wellness Dr.
Holland, MI 49424
616.994.0477
(f) 616.994.0105

Greenville

112 S. Clay
Greenville, MI 48838
616.754.5667
(f) 616.588.6517

Belding

405 W. Main Street
Belding, MI 48809
616.794.2510
(f) 616.794.1015

Welcome to Grand Rapids Ophthalmology! This packet was created to answer your questions and provide you with valuable information.

Please complete the Patient Information and Medical History forms and bring with you to your initial appointment along with the other items on the Patient Checklist. We realize that your time is very important and completing these forms will save you time in the office.

Also remember to bring insurance cards to each visit. An Insurance Programs Sheet is attached for your convenience.

Your eyes are dilated during a Complete Examination and they will remain dilated for approximately three hours. During this time, you will be unable to see well up close. Sunglasses are recommended following a dilated eye exam.

If the patient is under the age of eighteen, a parent or legal guardian must be present at the exam.

We have included a Grand Rapids Ophthalmology Welcome booklet for you to review. Please do not hesitate to ask any member of our staff for help if any questions or concerns arise.

Sincerely,

The Doctors & Staff of Grand Rapids Ophthalmology



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Please bring the following items to appointment:

- ❑ Out of pocket responsibility.
- ❑ Insurance co-pay, if applicable.
- ❑ All medical and vision insurance cards.
- ❑ Medical History form completed and signed.
- ❑ Patient Information form completed and signed.
- ❑ Complete list of all medications patient is currently using.
- ❑ If patient insurance plan states the need for a prior referral from his/her primary care physician, please remember every visit needs prior approval.
- ❑ ***If patient is a minor, parent or legal guardian must be present at initial visit. A waiver may be signed for subsequent visits.***

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INSURANCE PROGRAMS

Grand Rapids Ophthalmology is proud to announce our participation in the following insurance programs*. If your plan is not listed, please call our office since we are continually adding programs.

Adult Benefit Waiver Program	MEBS
Aetna	Medicaid-Straight
Aetna Medicare	Medicare
Always Care Vision	Medicare Complete
ASR/Physician Care	Medicare Plus Blue
BCBS FEP of Michigan	Medicare-Railroad
BCBS of Michigan	Molina Health Care of Michigan/March Vision
BCBS Vision of Michigan	Molina Advantage
Beech Street Network	Molina Medicare Options
BCN Advantage	Multi-Plan/WPPN
Blue Care Network	OptumHealth Vision (Spectera)
Blue Choice	Physicians Health Plan
Care Source	PHP Mid Michigan – Family Care
Children’s Special Health Care Services	Preferred Care/USA Care
Cigna	Preferred Choices
Cofinity (PPOM)	Principal Health
County Health Plan	Priority Health
Coventry	Priority Health Medicaid
Delta Vision	Priority Health Medicare
Ethix Great Lakes	Private Health Care System-PHCS
EyeMed/Eye Care Plan of America	ProAmerica
Fidelis Secure Care	Pyramid Medicare Advantage
First Health	Secure Horizons Direct Pacific Care
Grand Valley Health Plan	Select Care
Healthmarkets Care Assured	Tricare
Health Plan of Michigan	Unicare Security Choice
Heritage Optical	United Health Care
Humana	United Healthcare Vision
IBA Health Care	Universal Healthcare
McLaren Health Plan HMO, POS, PPO	Valley Advantage
McLaren Health Advantage	Vision Service Plan-VSP
McLaren Health Plan Medicaid	Worker’s Compensation

1. Grand Rapids Ophthalmology is a participating Medicare provider, therefore, we bill directly for covered services. Your insurance will pay according to the terms of your plan. Any co-pays, deductibles and exclusions will apply.
2. Many insurance plans will not pay for a refraction fee. This may be an out of pocket cost to the patient.
3. Many plans require a referral from your primary care physician for coverage.
4. Please be sure to know your insurance plan. We encourage you to call your insurance company if you have any questions relating to coverage.
5. We are here to serve you. Please feel free to call us if you have any questions 616.949.2600 or 800.968.2600.

*Plan participations subject to change without notice.

Patient # _____

Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Social Security # _____ Sex M F _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Home Phone () _____ Cell Phone () _____

Work Phone () _____ E-mail address as contact and/or to receive GRO Newsletter/Coupons _____

Referred by Doctor _____ MD DO OD _____

Family Doctor _____ MD DO OD _____

How did you hear about us? _____

Parent or Legal Guardian _____

VISION INSURANCE SUBSCRIBER / POLICY HOLDER

Check all that apply: EYE MED DELTA VISION SPECTERA
 BCBS VISION VSP Other _____

Subscriber Name _____ Relationship to Patient _____

Subscriber SS# _____ Subscriber Birth Date _____ Sex M F _____

Subscriber Address _____ City _____ State Zip Code _____

Home Phone () _____ Cell Phone () _____

Employer _____ Employer Phone () _____

Employer Address _____ City _____ State Zip Code _____

PRIMARY MEDICAL INSURANCE SUBSCRIBER / POLICY HOLDER

Check: Medicare Supplement _____ Medicaid _____
 BCBS Blue Care Network Other _____
 PPO PPOM/Cofinity Priority Health
 United Health Care Military Self Pay

Subscriber Name _____ Relationship to Patient _____

Subscriber SS# _____ Subscriber Birth Date _____ Sex M F _____

Subscriber Address _____ City _____ State Zip Code _____

Home Phone () _____ Cell Phone () _____

Employer _____ Employer Phone () _____

Employer Address _____ City _____ State Zip Code _____

PLEASE SEE REVERSE SIDE TO COMPLETE

Patient # _____

SECONDARY MEDICAL INSURANCE

SUBSCRIBER / POLICY HOLDER

- Check all that apply:
- | | | |
|---|--|--|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Supplement _____ | <input type="checkbox"/> Medicaid _____ |
| <input type="checkbox"/> BCBS | <input type="checkbox"/> Blue Care Network | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> PPO | <input type="checkbox"/> PPOM/Cofinity | <input type="checkbox"/> Priority Health |
| <input type="checkbox"/> United Health Care | <input type="checkbox"/> Military | <input type="checkbox"/> Self Pay |

<u>Subscriber Name</u>	<u>Relationship to Patient</u>	
<u>Subscriber SS#</u>	<u>Subscriber Birth Date</u>	<u>Sex M F</u>
<u>Subscriber Address</u>	<u>City</u>	<u>State Zip Code</u>
<u>Home Phone ()</u>	<u>Cell Phone ()</u>	
<u>Employer</u>	<u>Employer Phone ()</u>	
<u>Employer Address</u>	<u>City</u>	<u>State Zip Code</u>

WORKERS COMPENSATION (Complete if Applicable)

<u>Date of Injury</u>	<u>Authorizing Staff Member</u>
<u>Business Name</u>	<u>Business Phone ()</u>
<u>Business Address</u>	
<u>City</u>	<u>State Zip Code</u>
<u>Claim #</u>	

PERSON TO CONTACT IN AN EMERGENCY

<u>Name</u>	<u>Relationship to Patient</u>	
<u>Phone ()</u>	<u>Cell Phone ()</u>	<u>Work Phone ()</u>
<u>Address</u>		
<u>City</u>	<u>State</u>	<u>Zip Code</u>

I authorize the release of information to my insurance company & Assignment of Benefits
(Payment to Grand Rapids Ophthalmology)

Signature _____ (when applicable)

Date _____

Pt # _____
Date _____

PATIENT INFORMATION

Name	Birthdate	Age
Your Occupation	Eye Color	Sex M F
Current Medical Doctor		
Referring Doctor?		MD DO OD
Were you referred by another eye doctor?	Yes No	
If yes, please indicate name:		MD DO OD

E-mail address if you would like to receive our Free GRO Newsletter: _____

PAST OCULAR HISTORY

Last Eye Exam	Last Pair of Glasses
History of Eye Trauma	
History of Eye Surgery	

PAST & PRESENT MEDICAL HISTORY

Medication Allergies _____

Environmental Allergies _____

Current Medications _____

Eye Medications _____

Previous Surgeries _____

MEDICAL CONDITIONS

Personal		Personal		Family History			
Yes	No	Yes	No	Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Bone/Joint	<input type="checkbox"/>	<input type="checkbox"/>	Crossed or Lazy Eyes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blood/Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Problems	<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Fever/Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Blindness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Genital/Urinary	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Nervous System Disorders	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Mouth, Throat					
<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?					
<input type="checkbox"/>	<input type="checkbox"/>	Other (Please describe)					

Social History

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

• If you answered "YES" to the above, Please provide complete details on reverse side.

CONTINUED PERSONAL MEDICAL CONDITIONS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Sometimes people, especially family members, call regarding results of exams. To legally release your medical information to them, their names must be listed below. Listing their name(s) indicates you will allow us to tell them the details of your exam. We can only release information to the people you list below.

Name _____ Phone # () _____

Name _____ Phone # () _____

Name _____ Phone # () _____

Name _____ Phone # () _____

Grand Rapids Ophthalmology participates with most VISION and MEDICAL insurance plans.

- VISION plans cover exams specific to how your eyes see with glasses and/or contact lenses.
- MEDICAL insurance covers medical health issues affecting your eyes.

Patient Signature _____ Date _____