Patient Registration

Full Name ______________________ what would you like to be called ____________
Social Security # ______________Date of Birth ___/___/___ Age ___ Sex ☐ Male ☐ Female
Home Address ______________________________ Apt # ________
City ____________State _____ Zip ________ E-Mail Address ______________
Home Phone ______________________ Cell Phone ______________
Employer ________________Work Phone ________________ Ext _____
Spouse's Name ______________________________ Date of Birth ___/___/___

In Case of an Emergency, Contact: ______________________
Phone (   ) ______________________ ___Relationship ______________

RESPONSIBLE PARTY: *(if patient is under 18)*
Full Name ____
Relationship to Patient ______________________Date of Birth ___/___/___
Home Address ______________________________ Apt # ____________
City ______________________ State ____________ Zip ____________
Home Phone ____________ Work Phone ______________ Cell Phone ____________

HOW DID YOU HEAR ABOUT OUR OFFICE?
☐ Doctor (name) ________________ ☐ Yellow Pages ________________
☐ Optometrist (name) ______________ ☐ Friend/Relative/Previous pt. (name) ____________
☐ Internet (website) ______________☐ other ______________________

IS YOUR VISIT TODAY A WORK RELATED INJURY? ☐ YES ☐ NO
Employer Contact ______________________________ Phone ______________

INSURANCE INFORMATION:

Primary Medical Insurance
Subscriber ______________________
Subscriber Social Security # ______________
Subscriber Date of Birth ___/___/___
Insurance Co. Name ______________________
What is your Co-Pay ______________________

Secondary Medical Insurance
Subscriber ______________________
Subscriber Social Security # ______________
Subscriber Date of Birth ___/___/___
Insurance Co. Name ______________________
What is your Co-Pay ______________________

Please list your Vision Insurance
Subscriber ______________________
Subscriber Social Security # ______________
Subscriber Date of Birth ___/___/___
Insurance Co. Name ______________________
What is your Co-Pay ______________________

☐ I have no secondary insurance

☐ I have no vision Insurance

A refraction may be done to determine your need for glasses. Without a refraction, a prescription for glasses cannot be written.
A refraction may also be necessary if you have a medical eye condition causing a vision problem. A refraction is not a covered service by Medicare or most insurance plans. Our fee for a refraction is $35.00 and is collected at the time of your service.

I authorize: 1) Medicare or any other insurance plan to pay benefits directly to Oakland Eye Care, P.C. and 2) The release of my medical information to my insurance company to process my claims.
I agree to pay, at the time of service, for: 1) All services not covered by my insurance plan, 2) All services not authorized by my HMO, and 3) the co-payments and deductibles of my insurance plan, unless other payment arrangements have been made.

Signature of Patient or Guardian ______________________ Date ______________

Medical History Questionnaire

What eye concerns do you have?

____

____

____

Please answer the following if you have not done so above:

Which Eye? ______________________ Problem with Vision? ______________________

Type of Pain? ______________________ How Long? ______________________

Does something make your problem better/worse?

____

Please circle anything else associated with your problem:

Dryness	Itching	Watering	Redness	Sandy or Gritty Feeling
Aching	Burning	discharge	double vision	Light sensitivity

Past Medical History

LIST ALL CURRENT MEDICATIONS:

____

____

____

____

LIST ANY ALLERGIES INCLUDING ALLERGIES TO MEDICATIONS:

____

LIST ALL MEDICAL CONDITIONS: ______________________

____

LIST ANY SURGERIES YOU HAVE HAD INCLUDING THE EYES:

____

____

Review of Systems

Have You Had or Do You Currently Have:

	Yes	No
Constitutional Symptoms		
Fever	☐	☐
Weight Loss	☐	☐
Allergic/Immunologic		
Seasonal Allergies	☐	☐
Ears, Nose, Mouth, Throat		
Dry Throat/Mouth	☐	☐
Cardiovascular (heart/blood vessels)		
High Blood Pressure	☐	☐
Angina	☐	☐
Previous Heart Attacks	☐	☐
Congestive Heart Failure	☐	☐
Respiratory (lungs/breathing)		
Emphysema/COPD/Asthma	☐	☐
Tuberculosis	☐	☐
Gastrointestinal Disease (stomach/intestines)	☐	☐
Genitourinary Disease (genitals/kidneys/bladder)	☐	☐

	Yes	No
Musculoskeletal		
Joint Pain	☐	☐
Skin or Breast Disease	☐	☐
Neurological Disease	☐	☐
Psychiatric Disease	☐	☐
Endocrine (hormone System)	☐	☐
Diabetes	☐	☐
Thyroid Overactive	☐	☐
Thyroid Underactive	☐	☐
Removal or Destruction of Thyroid	☐	☐
Hematologic/Lymphatic		
Cancer	☐	☐
Anemia	☐	☐

If you need to elaborate on one of the above, please do so here: ______________________

____

____

Patient Name: ______________________

Family History

Patient Name: ______________________ Date: ____________

Has Anyone in YOUR FAMILY had: (exclude yourself and your spouse)

Disease	Yes	No	Relationship to patient
Blindness	☐	☐	____________
Glaucoma	☐	☐	____________
Macular Degeneration	☐	☐	____________
Retinal Detachment	☐	☐	____________
Other	☐	☐	____________

Social History

Current Occupation: ______________________

	Yes	No
Do you drive?	☐	☐
Do you have visual difficulty while driving?	☐	☐
Do you have problems with night vision?	☐	☐
Do you currently wear glasses or contact lenses?	☐	☐
Do you drink alcohol?	☐	☐
If yes, How many glasses a day? ____________		
Do you smoke?	☐	☐
If yes, how many packs a day? ____________		
If quit, when? ____________		
Have you had Hepatitis A, B or C?	☐	☐
Are you HIV positive or have had intimate contact with a person who is HIV positive?	☐	☐

Do Not Write Below This Line

History Reviewed: ☐ No Change ☐ Additions as Noted Below

____

____

Physician's Signature: ______________________ Date: ____________

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

Oakland Eye Care
Dr. Thomas Biggs, D.O.
Dr. Arlin French, D.O.

I, the undersigned, acknowledge that I can receive receipt of the Notice of Privacy Practices.

X____Date__________________
(Signature, Patient or personal representative)

If personal representative's signature appears above, please describe personal representative's relationship to the patient.

____

____

Please list the full name of any individual that we may speak to regarding your personal health information such as a spouse, sons, daughters, or a significant other. Without this authorization, no information may be released to anyone other than yourself.

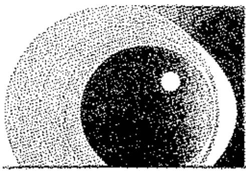
____Relationship________________
____Relationship________________
____Relationship________________
____Relationship________________
____Relationship________________
____Relationship________________

Please check the boxes that apply to you:

☐ You may leave health information on my answering machine.
☐ DO NOT leave health information on my answering machine.

☐ You may leave me voice mail at work that includes health information.
☐ DO NOT leave voice mail at my work which includes health information.

*To be filed and retained for a minimum of six (6) years
HIPPA form/acknowledgement/good faith efforts/06-08



Thomas W. Biggs, II, D.O.
Arlin H. French, D.O.

Oakland Eye Care

Dr. Thomas Biggs
Dr. Arlin French

Authorization and Agreement for Medical Treatment

Consent for Examination and Treatment

I understand that medical treatment may be necessary for the patient by Dr. Biggs or Dr. French and their technicians. I understand that the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examination to check abnormalities found and treated, lies with me and not Dr. Biggs, Dr. French, or their technicians.

For patients less than 18 years old, a parent or legal guardian must sign all consent forms giving Dr. Biggs or Dr. French and their technicians permission for medical treatment.

Patient Responsibilities

Thank you for choosing us as your eye care provider. We are committed to you and the success of your treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we request you read and sign prior to your treatment.

1. It is necessary that all patients complete the patient information forms prior to seeing the doctor.
2. Full payment is due at the time of service, unless we participate with your insurance company, including all co-pays, deductibles, and non-covered services. We accept cash, check, debit and credit cards (Visa and MasterCard.) Patients will be charged $35.00 fee for any check returned to us. Any unpaid balances may be referred to an outside collection agency for past due accounts.
3. Our office will submit claims to your insurance company as a service to you. Your insurance carrier cannot be billed unless you provide necessary documentation. We will only accept assignment of benefits for insurance plans we participate with. Any remaining balances after payment is received from your carrier are your responsibility and not that of your insurance carrier.
4. Due to the specialized nature of our practice we provide some services that are not covered by all insurance carriers. The staff will review these additional fees with you if we are aware of them. It is important that you know what your insurance plan covers since we cannot know coverage of all insurance plans.
5. HMO patients are responsible for obtaining the required referral prior to their office visit.
6. If your insurance company requires laboratory specimens to be sent to a specific lab, please know the participating lab and inform us. Be advised that laboratory charges are completely separate from our office.
7. A parent or guardian must accompany all minors. The adult accompanying a minor will be the responsible party for the payment of any services rendered.

Patient Signature ______________________________ Date ____________________

Parent or Guardian Signature ______________________ Date ____________________

Munk Professional Center / Suite 100 • 5825 South Main Street • Clarkston, Michigan 48346 • Phone: (248) 620-3000 • Fax: (248) 620-0110
Clarkston Medical Building / Suite 135 • 5701 Bow Pointe Drive • Clarkston, Michigan 48346 • Phone: (248) 922-0400 • Fax: (248) 922-9830

The following questions are mandated by the government not Oakland Eye Care.

PREFERENCE FOR CONTACT **(Please mark your first choice of contact)**

- ☐ Phone - HOME
- ☐ Phone – CELL
- ☐ Phone – WORK
- ☐ E-Mail ______________________________@__________________
- ☐ TEXT _________________________________
- ☐ U.S. Mail

PRIMARY LANGUAGE

List primary language; example English, Spanish, French etc...

____ ☐ Decline to answer

RACE (check one)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific
- ☐ White

- ☐ Decline to Answer

ETHNICITY

- ☐ **NOT** Hispanic or Latino
- ☐ Hispanic or Latino
- ☐ Unknown
- ☐ Decline to Answer

PATIENTS NAME____