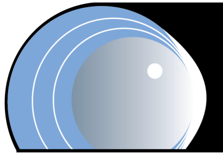


Ophthalmologist
Thomas W. Biggs II, D.O.
Arlin H. French, D.O.

Optometrist
Lauren E. Roderick, O.D.

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
☐ Email ____@___________________
☐ 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:____

Revised: May 22, 2018

OAKLAND EYE CARE

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 _________ Email Address __________________________________
Home Phone ___________________________________ Cell Phone __________________________________
Employer _____________________________________ Work Phone __________________________________
Spouse's Name ____ Date of Birth ____/____/_____

In Case of an Emergency, Contact: Name ____
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___________________________________
Cell Phone _____________________________________ Work 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 Copay ______________________________

Secondary Medical Insurance
Subscriber ____________________________________
Subscriber Social Security #______________________
Subscriber Date of Birth _____/______/_______
Insurance Co. Name ______________________________
What is your Copay ______________________________

Please list your Vision Insurance
Subscriber ___________________________________
Subscriber Social Security #______________________
Subscriber Date of Birth _____/______/_______
Insurance Co. Name ______________________________
What is your Copay ______________________________

□ 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**_____________________

Revised: May 22, 2018

OAKLAND EYE CARE

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 or 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 currently have:

Constitutional Symptoms	YES	NO
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)	☐	☐

Musculoskeletal	YES	NO
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:______________________

____
____

Patients Name: ____

Revised: July 10, 2017

OAKLAND EYE CARE

Family and Social History

Patient Name:____ Date:_______________________

Family History

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

<u>**Disease**</u>	**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 you 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?	☐	☐

Please do not write below this line.

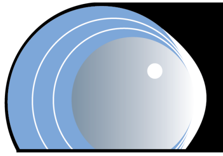
____

History Reviewed: ☐ No Change ☐ Additions as Noted Below

____

____

Physician's Signature: Date:



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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, Dr. French, or Dr. Roderick 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, and Dr. Roderick, or their technicians.

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

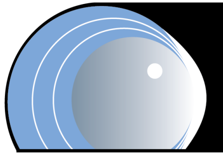
Patient Responsibilities

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 charges a $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 ______________



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Notice of Privacy Practices and Acknowledgment

I, the undersigned, acknowledge that a copy of Notice of Privacy Practices is available to me.

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 a voice mail at work that includes health information.
□ DO NOT leave me a voice mail at work that includes health information.

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