Lakeside Ophthalmology Center

Please take a few moments to fill out the following information. **Please be prepared to present your Insurance Card (s) and Drivers License or State ID with these forms along with a list of your Current Medications including eye drops, vitamins and supplements you may be taking.**

PLEASE PRINT

If you are new, how were you referred to our office_____

Patient Name_____
Last Name First Name Middle Initial

Parent/Guardian Name_____

Street Address_____

City_____State_____Zip_____

Home #(____)_____Work #(_____)_____Cell #(_____)_____

Date of Birth_____/_____/_____ Current Age_____Social Sec #_____-_____-_____
Sex M ☐ F ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐

Email address_____

Patient Employer_____Phone_____
Occupation_____

Medical Insurance Information
Subscribers Name_____Date of Birth_____/_____/_____

Vision Insurance Information
Subscribers Name_____Date of Birth_____/_____/_____

Family Physician_____Phone_____

Other Physician (s) you would like a letter sent to. Please include phone number (s).

_____

Emergency Contact_____Phone_____
Relationship_____

Patient / Parent or Guardian Signature **Date**

PLEASE SEE OTHER SIDE

Lakeside Ophthalmology Center

MEDICAL HISTORY QUESTIONNAIRE

Name: _____ **Date of Birth:** ____/____/_____

Referring Doctor:_____**Primary Care Physician:**_____

Pharmacy Name and Location (street & city):_____

Date of last eye exam_____**Name of Doctor / Facility**_____

Do you wear glasses? □ Yes □ No Do you wear contacts? □ Yes □ No Type/Brand_____

Ocular History: (Please mark all that apply) □ No history of eye problems

□ Amblyopia (Lazy Eye)
□ Iritis/Uveitis
□ Cataracts
□ Corneal Disorder
□ Diabetic Retinopathy
□ Astigmatism
□ Glaucoma
□ Hyperopia (Farsighted)
□ Floaters
□ Dry Eye Syndrome
□ Myopia (Nearsighted)
□ Retinal Detachment
□ Eyelid Disorders
□ Macular Degeneration

Other_____

Past Ocular Surgeries: (Please mark all that apply) □ No prior ocular surgery

R - L	R - L	R - L
□ □ Blepharoplasty (Lid Surgery)	□ □ Glaucoma Surgery / Laser	□ □ Strabismus (eye muscle surgery)
□ □ Cataract Surgery	□ □ Laser Retinal Surgery	□ □ Vitrectomy
□ □ Corneal Transplant	□ □ LASIK	□ □ YAG Laser Capsulotomy

Other_____

Other Medical History: □ No history of illnesses Are you Pregnant? □ Yes □ No

□ Anemia
□ Arthritis
□ Arrhythmia
□ Asthma
□ Cancer (specify below)
□ Congestive Heart Failure
□ COPD
□ Diabetes (circle: Type 1 or Type 2)
□ Fibromyalgia
□ Headache
□ Hearing Loss
□ Heart Attack
□ Hepatitis
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ HIV/AIDS
□ Kidney Disease
□ Liver Disease
□ Lupus
□ Migraine
□ Multiple Sclerosis
□ Polymyalgia Rheumatica
□ Psychiatric Disorder
□ Rheumatoid Arthritis
□ Stroke
□ Thyroid Disease

Other_____

Previous General Surgeries/Procedures: (Please list type and year)

_____ _____ _____

_____ _____ _____

Allergies:	**Reaction**	**Severity**
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe
_____	_____	mild / moderate / severe

Family History: (Please indicate relationship) □ No history of illnesses □ History unknown

□ Blindness
□ Cancer
□ Cataracts
□ Diabetes
□ Glaucoma
□ Heart Disease
□ High Blood Pressure
□ Lazy Eye
□ Macular Degeneration
□ Retinal Disease
□ Stroke
□ Other_____

Social History: (Please mark all that apply)

Smoking: □ current every day smoker □ current some day smoker □ former smoker □ never smoked

Alcohol Use: □ No □ Yes If yes, how much and how often?_____

Drug Use: □ No □ Yes If yes, which and how long?_____

Patient/Parent or Guardian Signature_____Date_____

Lakeside Ophthalmology Center

Everyday new insurance companies are forming, and present companies are changing. Consequently, it is impossible for us to know exactly what your insurance company will cover. Please check with your own insurance carrier, so you will be aware of your coverage and eligibility regarding: **OFFICE VISITS, TESTS, SURGERY, ROUTINE EYE EXAM, etc.** It is to your benefit to be well informed to prevent having to pay for a service that may have been covered if you had a referral or prior authorization.

It is our policy to make a copy of your Insurance Cards (Medical and Vision), as well as your Drivers License or State ID. Please be prepared to present these to the receptionist.

■ *I understand if I do not carry medical or vision insurance for the exam performed, I will be asked to pay the fees prior to being seen by the physician.*
■ *I understand that Lakeside Ophthalmology Center collects for all co-pays, deductibles and any charges not covered by my insurance prior to being seen by the physician unless other arrangements have been made between myself and Lakeside Ophthalmology Center.*
■ *I understand that I am responsible for my bill.*
■ *I authorize use of this form on all my insurance submissions.*
■ *I authorize release of information to all my insurance companies.*
■ *I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.*
■ *I authorize direct payment to my doctor.*
■ *I permit a copy of this authorization to be used in place of the original.*
■ *If I have managed care insurance coverage, I am responsible for obtaining a referral from my Primary Care Physicians prior to my appointment. I understand that my appointment will be canceled/rescheduled if I do not have a referral when I arrive for my appointment.*
■ *I am responsible for all charges not covered by my insurance company.*
■ *I understand that if I am seen for a Routine Vision Exam, medical testing might be necessary and ordered by the doctor. Medical testing is generally not covered by vision insurance companies. Lakeside Ophthalmology Center will bill my medical carrier for these tests as necessary.*
■ *I authorize the release of medical records to any physicians I may be referred to.*
■***By signing this, I am aware that Lakeside Ophthalmology Center has a Notice of Privacy in place and I may review a copy of it in the office or ask for a copy to be given to me for my records.***

Please sign below that you have read and understand the above:

Patient / Parent or Guardian Signature **Date**

PLEASE SEE OTHER SIDE

Lakeside Ophthalmology Center

IMPORTANT INFORMATION ABOUT YOUR VISION EXAM and OUR POLICIES

Patient Name:_____ **Date:**_____

Please make sure you bring your current pair of glasses at the time of your exam and an updated list of medications you are currently taking, including eyedrops.

During your exam, your eyes may be dilated by using medicated eye drops. This will cause your eyes to be sensitive to light. You may want to bring a pair of sunglasses with you at the time of your appointment to help reduce the glare and brightness of the sunshine. Even on a cloudy day certain conditions such as snow on the ground may cause enough brightness for sensitive eyes. We also carry a supply of disposable sunglasses for your use at no charge. Each patients sensitivity to dilation varies, most have no problem driving after dilation. If you feel you may need a driver, please do not hesitate to bring one with you, though it is not a requirement.

At the time of your visit, please present your insurance cards to the receptionist. **We will need both Medical insurance cards and any Vision insurance cards / information that you may have. It is very important that we have all insurance information.** Medical problems associated with your eyes are billed to your medical insurance. Any routine vision exams are billed to your vision insurance carrier if you have vision coverage.

Some insurance carriers require the patient to obtain an authorization (permission) to be seen. If your insurance plan requires this you must have the authorization before you are seen or you may have to reschedule until authorization is obtained.

There may be a **REFRACTION FEE** associated with your exam. A Refraction is a test that checks your VISION to see what your most accurate Eyeglass or Contact Lens prescription may be. This test is considered part of a Routine Eye Exam and is not covered by most insurance companies. Many insurance carriers including, **Medicare, Blue Cross Blue Shield and Medicaid may not pay for this service. Unless you are having a Routine Vision Exam – using your Routine Vision Insurance, you will be responsible for this fee and may be asked to pay for this service.**

If you are interested in contact lenses there may be a contact lens suitability exam fee in addition to your eye exam that may not be payable by your vision carrier. The Lens Boutique connected to our office may be dispensing your contact lenses. If you have any questions on their fees you may reach their office at (586) 228-9740.

Please sign below that you have read and understand the above:

_____

Patient / Parent or Guardian Signature **Date**

PLEASE SEE OTHER SIDE

Lakeside Ophthalmology Center

Name:_____ Date of Birth_____

Current Eye Medications: (Please list)

□ None

_____ _____ _____

_____ _____ _____

All Other Medications: (Please list and include any aspirin or vitamins)

□ None

Medication name	Dose	Directions	Reason for taking	Prescriber name

Patient/Parent or Guardian Signature_____Date_____

Lakeside Ophthalmology Center

Robert G. Mobley, M.D., P.C.

Notice of Privacy
and
Authorization to Disclose Information to a Third Person

Lakeside Ophthalmology Center will provide you with a copy of our "Notice of Privacy Policy" upon your request. By signing this form you understand Lakeside Ophthalmology Center Notice of Privacy and HIPAA Policies.

I,_____ authorize the following individual(s) ***Family member/friend*** to receive my protected health information in the event that I am unable to be contacted, or if I become incapacitated. I also consent to this authorization allowing a representative from Lakeside Ophthalmology Center to discuss my account receivable records with the individual(s) listed below.

I understand that the individuals not listed (including my spouse) may not receive my information without my authorization under the Health Insurance Portability and Accountability Act of 1996, (HIPAA).

Authorized Person _____

Relation to patient _____

Authorized Person _____

Relation to patient _____

Authorized Person _____

Relation to patient _____

OR

I do not give permission for any family member/friend to receive my protected health information.

Please initial _____

Patient Signature _____ Date _____

Or Parent/Guardian

Witness _____ Date _____

Executive Square • 42524 Hayes, Suite 400 • Clinton Township, Michigan 48038 • (586) 263-1168 • Fax (586) 263-1169