BAY EYE ASSOCIATES
10161 E. Pickwick Ct., Suite C
Traverse City, MI 49684

Telephone: 231-935-0630

Fax: 231-935-0639

Martin S. Arkin, M.D., Ph.D.

Dear _____, Welcome to Bay Eye Associates!

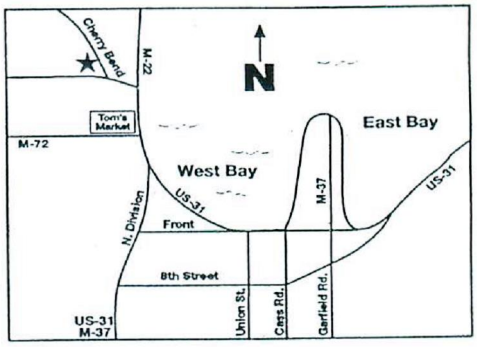
You have an appointment with Dr. _____ on: _____ at _____

Please bring with you:

- **The 3 enclosed forms (Please complete prior to your appointment)**
- **All of your medical & vision insurance cards**
- **Your eyeglasses and/or contact lens**
- **A list of your current medications**
- **Any insurance co-pay that may be due at the time of service**

Your appointment is at the office indicated below:

☐ **Traverse City office, located on the main floor at 10161 E Pickwick Ct, Traverse City in Ste. C**



Follow M-22 along Grand Traverse Bay, to Cherry Bend Rd. Turn west, go ¾ of a mile to Pickwick Center Building, located next to Cherry Bend Grocery

☐ **Frankfort office, located in the Office Building, 228 7th St, Frankfort**

Follow M-115 West/Frankfort Hwy,
Go North onto 7th St/Bellows St, 228 7th St

Parking Available

If you should have any questions, please contact our office at (231) 935-0630.

Sincerely,

The Staff at Bay Eye Associates

PATIENT REGISTRATION

Bay Eye Associates
10161 E. Pickwick Ct., Ste. C, Traverse City, MI 49684

TODAYS DATE:_____

Patient Last Name _____ **First** _____ **Middle Initial** _____ **Mr / Mrs / Ms Dr / Rev / Miss**

Mailing Address _____

City _____ **State** _____ **Zip Code** _____

****PREFERRED PHONE NUMBER**
( )
Ĭ HOME Ĭ CELL Ĭ WORK

Sex: ☐ M ☐ F **Date of Birth:_____ AGE:_____**

( )
Alt. Phone (Circle) HOME CELL WORK

Email Address: _____ **Social Security #:** _____

Employer: _____ Phone: ( ) _____ Occupation: _____

● *IN CASE OF EMERGENCY PLEASE CONTACT*:

Name: _____ ( ) _____
Relationship (Circle 1) Spouse Parent Relative Friend Other

● *SECONDARY ADDRESS- SUMMER/WINTER*

_____ Phone: ( ) _____
Mailing Address City State Zip

Dates at secondary residence: _____ til _____

● *BILLING INFORMATION IF DIFFERENT THAN ABOVE PARENT/GUARDIAN (if patient is under 18 years of age*

*****CHECK ONE:* ☐ **Billing Information** ☐ **Parent/Guardian Information**

Name: _____ Date of Birth: _____

Address(if different): _____ Phone: _____

Employer: _____ Phone: _____

● *INSURANCE CARDHOLDER INFORMATION*

If the patient is NOT the cardholder, Please provide the subscriber's information below

Insurance: _____ Subscriberôs Name:_____ DOB: _____

Patient Relationship to Subscriber: SPOUSE CHILD OTHER:_____ SS#: _____

Who referred you to our clinic? Ĭ FRIEND Ĭ FAMILY Ĭ DOCTOR_____
Ĭ Newspaper Ĭ Radio Ĭ Website Ĭ Other_____

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Traverse City, MI 49684

PATIENT MEDICAL HISTORY RECORD DATE: _____

NAME: _____ DATE OF BIRTH: _____

PRIMARY CARE DOCTOR: _____ PREFERRED PHARMACY:_____
PHARMACY PHONE #: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you ever been treated for any medical conditions (e.g.,diabetes, high blood pressure, arthritis, etc.)?
   YES NO EXPLAIN: _____
2. Have you ever had any eye disease (e.g., glaucoma, cataract, wandering or "lazy eye", retinal detachment)?
   YES NO EXPLAIN _____
3. Have you ever had ANY surgery?
   YES NO DATE & TYPE: _____
4. Have you ever been hospitalized:
   YES NO DATE & REASON: _____
5. Do you take ANY medications: (including eye medications) PLEASE USE BACK OF THIS PAGE, IF YOU NEED MORE ROOM
   YES NO PLEASE LIST: _____
   _____
6. Do you have any drug or food allergies?
   YES NO PLEASE LIST: _____
7. Have you taken any of the following medications in the last 5 years: PLEASE CIRCLE IF YES

Hytrin (Terazosin) **Cardura** (Doxazosin) **Uroxatral** (Alfuzosin) **Flomax** **Saw Palmetto** (Herbal Supplement)

DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING?			**IF YES, PLEASE EXPLAIN:**
Chronic fever, unexpected weight loss/gain, fatigue	YES	NO	_____
Ear, nose, throat problems (hearing loss, sinus problems, sore throat)	YES	NO	_____
Heart Problems ((chest pain, irregular heart beat)	YES	NO	_____
Respiratory Problems (shortness of breath, wheezing, coughing)	YES	NO	_____
Gastrointestinal Problems (heartburn, abdominal pain, diarrhea, vomiting)	YES	NO	_____
Urinary Problems (pain or discomfort, blood in urine)	YES	NO	_____
Skin Problems (rashes, excessive dryness)	YES	NO	_____
Musculoskeletal Problems (muscle aches, joint pain, swollen joints)	YES	NO	_____
Neurologic Problems (numbness, weakness, headaches, paralysis)	YES	NO	_____
Psychiatric Problems (depression, anxiety)	YES	NO	_____

FAMILY & SOCIAL HISTORY (IF YES, PLEASE EXPLAIN)
Do any medical or eye diseases run in your family (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?
YES NO _____
Do you smoke? YES NO If yes, how much? _____
Do you drink alcohol? YES NO If yes, how much? _____

COMMENTS:_____
_____
_____

DOCTOR SIGNATURE: _____
☐ **Martin Arkin, M.D.** ☐ **Kevin Nelson, O.D.**

BAY EYE ASSOCIATES ***(231) 935-0630***

BRING YOUR INSURANCE CARDS TO EVERY APPOINTMENT & ADVISE OF ANY CHANGES

PAYMENT FOR SERVICES MEDICARE and OTHER CONTRACTED INSURANCE PLANS

We will file a claim directly to Medicare and/or Blue Cross Blue Shield or other commercial insurance plans with which we are contracted, and we will accept assignment on the claim, which means that we should be paid directly by insurance, and receive an Explanation of Benefits. It is your responsibility to pay any deductible, coinsurance, co-payment, and/or any non-covered services, such as refraction or eyeglasses.

NON-CONTRACTED INSURANCE PLANS

Your insurance is a method for you to receive reimbursement of fees you have paid to the physician. Having insurance is not a substitute for payment. You must pay 100% of your bill, but in some circumstances, as a courtesy, we MAY accept assignment for the claim, which means that your insurance company should send us their payment directly, along with the Explanation of Benefits, and you will then be responsible for any remaining balance. If we do not choose to accept assignment, you will be expected to pay 100% of your bill, and as a courtesy we may assist you in receiving reimbursement from your insurance carrier

REFRACTION FOR DETERMINATION OF VISUAL NEEDS

Traditional Medicare never pays for refractions. Other insurance plans may or MAY NOT pay for refractions. If your insurance company does not cover refractions, you will be responsible for the **$35 refraction fee.**

NOTICE OF PRIVACY PRACTICES

Bay Eye has a copy of the HIPAA Notice of Privacy Practices in the waiting room to read at my convenience.

EMAIL,TEXT MESSAGE

Bay Eye Associates may occasionally send messages for the purposes of reminder appointments medical bills, or other non-urgent information. We do not sell this information.
If you do not consent to receiving these reminders, please notify our staff.
If you are having any problems, do not send an email, Please contact the office directly (231) 935-0630

I authorize Medicare and/or other health insurance companies to send payments and Explanation of Benefits directly to Bay Eye Associates for any services furnished to me by Bay Eye Associates staff or physicians. I authorize any holder of medical, or other information about me, to release to Medicare and its agents, or my health insurance company and its agents, and/or corresponding physicians and/or medical personnel for continuation of care, any information needed to determine benefits or the benefits payable for related services.

I understand that I am financially responsible for all charges and if my insurance company pays me directly rather than Bay Eye Associates, I agree to send full payment to Bay Eye Associates within the same week.

I hereby voluntarily consent to the rendering of such care and treatment (such as examinations, procedures, diagnostic services, and testing that has been ordered by my provider and carried out by clinical staff. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all Bay Eye Associates affiliated providers and staff.

X _____ _____

Patient/Guardian Signature **Date**
(or power of attorney with appropriate documentation)