EYES OF OREGON - TILLAMOOK

David A. Biggar, OD

102 Main Ave
Tillamook, OR 97141
Ph: 503-842-4202 Fx: 503-842-1002

PATIENT REGISTRATION

MR MRS MISS MS DOC Male Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State | Zip

Last 4 of Soc Sec | Date of Birth | Email Address

Can we e-mail you reminders for your appointments? Yes No

Best Contact Phone # | 2nd Best Contact Phone #

circle Cell Home Work Cell Home Work Email

Emergency contact | Relationship to patient | Phone #:

Hobbies:

How did you hear about us?

Payment Policy: Payment is required when services are rendered. Patient portion of glasses and contacts is due when materials are ordered. $25 fee for returned checks. Accounts are charged a $10 monthly billing fee. Accounts not paid in full within 120 days of service are considered delinquent. Delinquent accounts are assessed $50 for collection efforts and are reported to credit bureaus.

Insurance Policy: As a courtesy we bill most insurance companies. Insurance is a contract between you and the insurance company. We try to determine your benefits, but cannot control accuracy of the information we receive. Medicare and insurance companies will only pay for services they determine to be "reasonable and necessary" and "covered" under your plan. If payment is denied we will assist you to get your maximum benefit, but you are ultimately responsible for all charges.

Double Coverage: Because insurance companies handle double coverage in ways we cannot predict, we may require payment based on your primary coverage and have you receive reimbursement directly from the second company.

Cancellation Policy: If you are unable to keep any future appointments please call us as soon as possible. If you do not give us 24 hour notice a $25 donation to the Optometry Giving Sight is collected in lieu of a No Show Fee. This donation helps five needy people receive the gift of sight (eye exam & glasses). www.GivingSight.org for more information.

Employer: **Occupation:**

Vision Insurance

Carrier:
Primary Insured/DOB:
ID #:
Group #:

Medical Insurance

Carrier:
Primary Insured/DOB:
ID #:
Group #:

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Eyes of Oregon. I understand that I am financially responsible for all charges. I also authorize Eyes of Oregon and my insurance company to release any information required to process claims.

X

Patient/Guardian signature: **Date**