EYE MEDICAL CENTER
OF FRESNO

1360 E Herndon Ave # 301, Fresno, CA 93720 | 559-486-5000

NEW PATIENT INFORMATION

Date of Appointment: _____ **(Please complete in full)** Doctor: _____

Patient First Name: _____ Middle Name: _____ Last Name: _____

If patient is a minor, name of responsible parent: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Spouse's Cell Phone: _____

Social Security Number: _____ Birth Date: _____ Age: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Race

- ☐ Alaskan Native
- ☐ Black or African American
- ☐ Hispanic
- ☐ More than one race
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Pacific Islander
- ☐ Patient Declines Reporting
- ☐ American Indian or Alaska Native
- ☐ Greek
- ☐ Hispanic or Latino (All Races)
- ☐ Multi-racial
- ☐ Other Pacific Islander (Not Hawaiian)
- ☐ White (Not Hispanic/Latino)
- ☐ Asian
- ☐ Hawaiian
- ☐ Indian
- ☐ Native American Indian
- ☐ Other Race
- ☐ White

Language: _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declines Reporting

Responsible Party employed by: _____ Occupation: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Business Phone: _____

Email Address (Will only be used for communication between you and us): _____

Name of Spouse: _____ Spouse employed by: _____

Family Physician: _____

Relative (other than spouse): _____ Phone: _____

Whom may we thank for referring you to this office? _____

Preferred Pharmacy: _____

Pharmacy Location: _____

The above information shall remain confidential unless released by your authorization.

X _____ _____

Signature **Date**

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REVIEW OF SYSTEMS

Patient Name: _____ Date of Birth: _____ Today's Date: _____

In each area below, if you are not having any difficulties, please check "No." If you are experiencing any of the symptoms listed, PLEASE CHECK THE ONES THAT APPLY, or add any that may not be listed. If you have any questions, please ask one of our technicians or your doctor.

Const. (Health in general)

☐ No ☐ Lack of energy ☐ Loss of appetite ☐ Fever
☐ Unexplained weight gain or weight loss ☐ Night sweats
Other: _____

C-V (Heart and Blood Vessels)

☐ No ☐ Irregular heartbeat ☐ Chest pains
☐ Swelling of feet or legs
Other: _____

Endocrinologic (Glands)

☐ No ☐ Intolerance to heat or cold
☐ Frequent hunger/urination/thirst
Other: _____

Integ. (Skin, Hair and Breast)

☐ No ☐ Persistent rash ☐ Itching ☐ New skin lesion
☐ Change in existing skin lesion ☐ Breast changes
Other: _____

Eyes, Ear, Nose, Mouth, Throat

☐ No ☐ Hearing loss ☐ Sinus problems ☐ Runny nose
☐ Ringing in the ears ☐ Mouth sores ☐ Ear pain
☐ Nosebleeds ☐ Sore throat
Other: _____

GI (Stomach and Intestines)

☐ No ☐ Heartburn ☐ Constipation ☐ Diarrhea
☐ Abdominal pain ☐ Difficulty swallowing ☐ Nausea
☐ Vomiting
Other: _____

Neurologic (Brain and Nerves)

☐ No ☐ Frequent headaches ☐ Double vision ☐ Tremor
☐ Weakness ☐ Dizziness ☐ Episodes of visual loss
Other: _____

MS (Muscles, Bones, Joints)

☐ No ☐ Joint pain ☐ Aching muscles ☐ Shoulder pain
☐ Swelling of joints ☐ Bck pain
Other: _____

Resp. (Lungs and Breathing)

☐ No ☐ Shortness of breath ☐ Prolonged cough
☐ Wheezing ☐ Oxygen at home ☐ Coughing up blood
Other: _____

GU (Kidney and Bladder)

☐ No ☐ Painful urination ☐ Frequent urination
☐ Urgency ☐ Prostate problems ☐ Nladder problems
Other: _____

Psychiatric (Mood and Thinking)

☐ No ☐ Insomnia ☐ Irritability ☐ Depression ☐ Anxiety
Other: _____

Hematologic (Blood/Lymph)

☐ No ☐ Easy bleeding ☐ Easy bruising ☐ Anemia
☐ Leukemia ☐ Unexplained swollen areas
Other: _____

Allergic/Immunologic

☐ No ☐ Seasonal allergies ☐ Itching ☐ Frequent infections ☐ Exposure to HIV
Other: _____

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PATIENT HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Medical History

	Y	N
Arthritis	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Thyroid	☐	☐
Stroke	☐	☐
_____	☐	☐
_____	☐	☐

Surgical History (Including Eye Surgery)

Type of Surgery	Year

Family History

	Y	N	If yes, family member
Amblyopia	☐	☐	
Blindness	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal Disorders	☐	☐	
Strabismus	☐	☐	

	Y	N	If yes, family member
High Blood Pressure	☐	☐	
Diabetes	☐	☐	
Heart Disease	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Cancer	☐	☐	
Respiratory Disease	☐	☐	
Circulatory Disorders	☐	☐	

Social History

Tobacco Use

Current ☐ Type: _____ Amt. per day: _____

Former ☐ Type: _____ Amt. per day: _____

Never ☐

Unknown ☐

Drug Use/Abuse

Yes ☐ Type: _____

No ☐

Formerly ☐

Passive Smoke Exposure

Yes ☐

No ☐

Caffeine Use

Yes ☐ Cups per day: _____

No ☐

Alcohol Use

Yes ☐ Amt. per day: _____

No ☐

Occupation: _____

Level of Education: _____

X _____
Signature

_____
Date

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MEDICATIONS

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Current Medications

Date	Medication	Dose Description

Allergies to Medications

Date	Medication	Reaction

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PRIVACY POLICY ACKNOWLEDGEMENT

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Patient or Personal Representative Use Only

Your Personal Health Information
The Privacy Policy Acknowledgement of Eye Medical Center

Federal law now requires us to request from you an agreement that we can disclose personal health information, such as your glasses prescription or conditions of your eye or general health, to authorized parties. These may include such entities as your other doctors, pharmacies, optical shops and your insurance carriers. We have a detailed Notice of Privacy Practices available for a more complete description of our policies if you wish to read it.

The Eye Medical Center will not make available any personal health information to any other persons without your specific prior written consent. We will honor any request from you to limit the exchange of information about your health condition if we are able to do so without impairing our ability to provide good medical care. We each retain the right to terminate our professional relationship if we disagree on this policy.

Your signature below indicates that you have read and understand this Privacy Policy.

X _____ _____

Patient or Personal Representative Signature **Date** **Personal Representative's Relation to Patient**

Provider Use Only

Documentation of Good Faith Effort

The patient identified above was given an opportunity to review the Privacy Policy of The Eye Medical Center. A good faith effort has been made to obtain a written acknowledgement from the patient, however acknowledgement has not been obtained because:

☐ Patient declined to sign the Privacy Notice Acknowledgement because:

_____

☐ Patient was unable to sign because:

_____

☐ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.

☐ Other reason, described below:

X _____

Employee Signature **Date**

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FINANCIAL POLICY

Thank you for choosing the Eye Medical Center as your eye care provider. We are dedicated to providing the best possible care, and regard the understanding of our financial policies as an important element of care and service. If you have any questions, please do not hesitate to discuss them with our business office staff.

INSURANCE COVERAGE

It is your responsibility to provide our office with accurate information for billing your health plan properly at the time of service, including current insurance identification cards, billing address and any other information required by your insurance carrier for payment of the claim. Please be advised that you will be responsible for the full amount of the charges incurred if incomplete or incorrect information is provided.

You are responsible for payment of any deductibles or non-covered benefits. We will submit an insurance claim on your behalf. If your insurance company denies payment, you will be financially responsible for the services provided. Remember that insurance authorizations/referrals for services do NOT guarantee benefits or payments. If your insurance fails to pay in full within 60 days, we ask that you contact your carrier with any questions, since at that time any account balance will then become your responsibility.

Insurance co-payments will be collected at the time of service. If we do not participate with your insurance plan or you do not have insurance coverage, you are to provide payment in full at the time of service, or arrange a payment schedule with our Financial Counselor. We gladly accept cash, personal checks and major credit cards.

MEDICARE

We accept assignment on Medicare claims. You are responsible for deductibles, co-pays and non-covered benefits. Medicare and most other carriers will **not cover the Refraction portion of the examination**. (This portion of the examination determines whether your vision can be improved with glasses and is necessary to dispense glasses.) **Therefore, we want you to be aware that there is a $40 charge for this refraction service due at the time of service.**

REFUNDS

Please note that all product sales are final. Refunds for cancellation of services or overpayments will be reimbursed on a monthly basis (30-days). Payments made by credit card will be refunded back on the same credit card, some restrictions do apply. Cash and check refunds will be distributed by mail to the address we have in our system, in the form of a check. It is your responsibility to provide our office with the most up to date address. For all address changes, please request a form from our front desk.

NO SHOW FEE

Eye Medical Center is dedicated to providing the best optical services to all of our patients. We require that you notify the office of any changes to your appointment as soon as possible. There will be a $50.00 fee for any missed appointments if the office is not provided with the cancellation notice 24 hours in advance of the scheduled appointment. EMC also considers late arrivals, exceeding 15 minutes, without communication to the office, as a missed appointment. This fee will be charged directly to you and is **NOT COVERED** by insurance. All no show fees must be paid prior to scheduling any new appointments.

FORMS COMPLETION POLICY

From time to time, you may have forms that need to be completed for various reasons. Completing paperwork for schools, camps, the Family Medical Leave Act (FMLA) claims, long-term care, life insurance, disability claims or other purposes goes beyond routine medical care. Unfortunately, it is not a covered benefit with your insurance plan. Since all forms require our signature, we are personally responsible for the accuracy of the information provided. Filling out forms thus requires careful consideration and considerable amount of time.

Therefore, it is our policy to charge for the completion of any form at the cost of $25.

Normal processing time to complete a form is 5-7 business days.

CREDIT CARD SURCHARGE

All credit and debit card transactions will be subject to a 3% surcharge. This fee is not greater than the total cost of accepting these transactions. This surcharge fee does not apply to cash, check, or money order transactions.

NOTICE OF SIGNIFICANT BENEFICIAL INTEREST

We are providing this notice to inform you that your doctor may have a significant beneficial interest in The Eye Medical Center of Fresno, Inc., The EyeWear Center at The California Eye Institute, Our physician owners in The Eye Medical Center of Fresno, Inc. and The EyeWear Center at The California Eye Institute, California Business and Professionals Code Section 654.2, requires your physician to notify you when your physician has a `significant beneficial interest,' as the term is defined under Section 654.2 in any organization to which your physician refers you for services. The owners at

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FINANCIAL POLICY

Fresno Surgical hospital and Summit Surgical are: George A. Bertolucci, M.D., Maziar Bidar, M.D., Mehdi Ghajar, M.D., Neesurg Mehta, M.D., Richard N. Mendoza M.D., Dan C. Prescott, M.D., Carolyn Sakauye, M.D., Laura Teasley, M.D., Sumeer Thinda, M.D.

Please be advised that you may choose any organization for the purpose of obtaining services ordered or requested by your doctor. The following addresses are provided for the filing of any complaints relevant to this notice or the services provided: Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815; Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95834.

ROUTINE AND MEDICAL EYE EXAMINATIONS

Our office participates with certain vision plans for "routine eye exams." A routine eye exam is, by definition, a "regular check-up" for someone with no eye problems. If the doctor detects any medical condition, (dry eyes, floaters, etc.) the examination becomes a medical eye examination and may be submitted to your medical insurance carrier. Our office cannot change a procedure/diagnosis code solely for the purpose of securing reimbursement from your insurance carrier. Please note that some insurance plans consider a routine eye exam to be a non-covered service. I have read the above policy and agree to comply with its provisions. I acknowledge that I am responsible to understand my insurance benefits and that I am responsible for payment of all medical services rendered. I understand that if I am covered by an insurance plan, Eye Medical Center of Fresno, Inc. may bill my insurance plan as a convenience to me, but that I am responsible for such charges until they are paid in full.

Assignment and Release: I hereby authorize my insurance benefits to be paid directly to Eye Medical Center of Fresno, Inc. and that I am financially responsible for services that my insurance company considers to be non-covered. I authorize Eye Medical Center of Fresno, Inc. to release any information required to process my claim.

Patient Name (print)

Signature of Patient (or Responsible Party if a Minor)

Date