EYE MEDICAL CENTER
OF FRESNO

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

Date of Appointment ________________

Doctor ________________

New Patient Information

(Please complete in full)

Patient Name (Do not use initials)________________
First Middle Last

If patient is a minor, name of responsible parent________________

Home Address________________ Home Phone________________

Cell Phone________________ Spouse's Cell Phone________________

City________________ State________________ Zip Code________________

Social Security Number________________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birth Date________________ Age________________ ☐ Male ☐ Female

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

Language________________

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

Responsible Party employed by________________ Occupation________________

Business Address________________ 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________________**Location**________________

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

Date________________ Signature________________

EYE MEDICAL CENTER OF FRESNO

Patient Name____________________________

Date of Birth______________________________ Today's Date_________________________

REVIEW OF SYSTEMS

In each area below, if you are not having any difficulties, please check "No." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE 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, unexplained weight gain or weight loss, loss of appetite, fever, 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, weakness, dizziness, tremor, episodes of visual loss. Other:____

MS (Muscles, Bones, Joints) ☐ No Joint pain, aching muscles, shoulder pain, swelling of joints, back 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, bladder 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:____

Patient Name____________________________

EYE MEDICAL CENTER OF FRESNO

Date of Birth____________________________

Date____________________________

MEDICAL HISTORY

	Yes	No
Arthritis	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Thyroid	☐	☐
Stroke	☐	☐
Other____________	☐	☐
Other____________	☐	☐
Other____________	☐	☐

SURGICAL HISTORY

Including Eye Surgery

Type of Surgery	Year

FAMILY HISTORY

	No	Yes	If yes, family member
Amblyopia	☐	☐	
Blindness	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	
Macular Degeneration	☐	☐	
Retinal Disorders	☐	☐	
Strabismus	☐	☐	

	No	Yes	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 ☐

Passive Smoke Exposure

Yes ☐

No ☐

Alcohol Use

Yes ☐ Amt. per day__________________

No ☐

Drug Use/Abuse

Yes ☐ Type____________________

No ☐

Formerly ☐

Caffeine Use

Yes ☐ Cups per day______

No ☐

Occupation__________________________

Level of Education____________________

____
Physician's Signature

____
Date

EYE MEDICAL CENTER
OF FRESNO

Patient Name____________________________

Date of Birth_____________________________

CURRENT MEDICATIONS

Date	Medication	Dose Description

ALLERGIES TO MEDICATIONS

Date	Medication	Reaction

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.

______________________________ ______________________

Patient or Personal Representative Signature Date

____

Personal Representative's Relation to Patient

ABOVE - Patient or Personal Representative Use Only

BELOW - 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:

  ____

  ____

______________________________ ______________________

Employee Signature Date

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.

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

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. 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, Fresno Surgical Hospital, and Summit Surgical. Our physician owners in The Eye Medical Center of Fresno, Inc. and The EyeWear Center at The California Eye Institute are: George A. Bertolucci, M.D., Maziar Bidar, M.D., Mehdi Ghajar, M.D., Richard N. Mendoza, M.D., Carolyn M. Sakauye, M.D., Dan C. Prescott, M.D., and Sumeer Thinda, M.D. Our physician owner in Summit Surgical is Maziar Bidar, M.D. Our physician owners in Fresno Surgical Hospital are: George A. Bertolucci, M.D., Mehdi Ghajar, M.D., Richard N. Mendoza, M.D., Laura Teasley, M.D., Sumeer Thinda, M.D., Dan C. Prescott, 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