1031 W. Chapman Ave #204, Orange CA 92868
2200 E. Fruit St. Suite 101, Santa Ana CA 92701

714-997-7000

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: ( ) _____ Cell Phone: ( ) _____

CA Driver's License # _____ EMail Address: _____

Social Security Number or Government ID: _____

DOB: _____ Marital Status: _____

Gender (circle one) Male Female Unknown

Occupation: _____ **Employer:** _____

Family Doctor's Name: _____ **Phone:** _____

Do you have an Optometrist? **Y / N** If Yes, please print name: _____

Insurance Information

Primary Insured Name and Date Of Birth: _____

Insurance Carrier:

In Case of Emergency

Full Name: _____
Last ***First*** ***M.I.***

Primary Phone: ( ) _____ **Alternate Phone:** ( ) _____

Relationship: _____

Please continue to the next page.

Patient Demographics

We are required by federal law to ask you for the following information:

1. **What is your gender?**
   ☐ Male ☐ Female

2. **What is your date of birth?** _____
   (month/date/year)

3. **What is your race?**
   ☐ American Indian/Alaskan Indian
   ☐ Asian
   ☐ Black or African American
   ☐ Hispanic
   ☐ Native Hawaiian/Pacific Islander
   ☐ Refuse to Report/Unreported
   ☐ White
   ☐ Other Please specify:_____
   ☐ I decline to answer.

4. **What is your ethnicity?**
   ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ I decline to answer.

5. **What is your preferred language?** ☐ English
   ☐ Spanish
   ☐ Other Please specify:_____

6. **Are you diabetic (have been diagnosed with Diabetes Mellitus)?**
   ☐ Yes ☐ No ☐ Not sure, possibly

7. **Do you smoke?**
   ☐ Current everyday smoker
   ☐ Never smoker
   ☐ Current some day smoker
   ☐ Former smoker

   Go to: http://healthit.hhs.gov/portal/server.pt/community/electronic_medical_records/1219/home/15591

Patient Clinical History Form

1. What is the main reason for your visit today?

2. Allergies to Medications

Please list any allergies to medications, along with your reaction:

3. Ocular History

Please indicate below if you have had any previous eye conditions:

4. Ocular Surgical History

Please indicate below if you have had any previous eye surgery:

5. Medical History

Please write down any medical conditions you have or have had.

6. Medication History

Please write down any medications you are currently taking, *including eyedrops*, and including herbal supplements.

7. Surgical History

Please write down any surgeries, of any type, that you have had. Please also list the year of the surgery.

8. Family History

Please indicate any relevant family medical history

9. Special Situations

Are you pregnant?	No	Yes
Are you possibly pregnant?	No	Yes
Are you breastfeeding?	No	Yes

Financial Responsibility Policy

I, the undersigned below, request that payment of authorized medical insurance benefits be made on my behalf to the MD EyeCare ("MDEyeCare") for services furnished to me by any provider associated with MD EyeCare. I authorize any holder of medical information about me to release to the appropriate medical insurance administration and its agents any information needed to determine benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA 1500 form or elsewhere on other claim forms, my signature authorizes releasing the information to the insurer or agency shown.

If so determined by a written contract between MD EyeCare and my medical insurer, then MD EyeCare accepts the charge determination of the insurance carrier as the full charge, and I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the medical insurance carrier. If no contract exists between MD EyeCare and my insurance, then I agree to accept full responsibility for the difference between the insurance reimbursement received by MD EyeCare and the charges for services rendered.

If I represent that I have medical insurance, I accept responsibility for all charges for services furnished to me by MD EyeCare in the event that it is determined that I was not eligible or authorized to receive such services at the time of service. **If I provide insurance information that is incorrect or invalid, I accept responsibility for payment for services.** I understand that at the time of service, I am responsible for payment in full of any copayments, out-of-network visit costs, prior outstanding balances, deductibles, and coinsurance.

If I do not pay the due balance in full at the time of service, I agree that a convenience fee of $25 will be added to my balance due. The convenience fee may be waived at the discretion of MD EyeCare.

If I do not fulfill my financial obligations to MD EyeCare, I will be sent written invoices detailing my obligations. **The balance of any account not paid within ninety (90) days will begin to accrue interest at the rate of 1.5% per month or the maximum allowed by applicable law, whichever is lower.** For small balances, between $.01 to $20.00, MD EyeCare may stop sending billing statements any time after the initial statement, but I understand that the amount shall remain due and owing until paid in full.

At the discretion of MD EyeCare, my account may be referred to a collection agency for failure to clear an outstanding balance. **If I am referred to collections, a $95 collections/billing fee will be added to my balance due, along with any costs (including attorney fees, courts costs, and filing fees) necessary to enforce collection of the amount due.**

MD EyeCare accepts cash and credit cards. Personal checks are accepted from established patients, and are never accepted for new patients. **If a personal check is returned by the bank for any reason, I will be responsible for a returned check fee of $45**, which includes the bank's returned check fee and the office administrative costs in handling a returned check. A copy of this policy is available to me upon my request.

Patient Signature:_____ **Date:**_____

1031 W Chapman Ave
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FAX 714-538-1142

2200 E Fruit St
Suite 101
Santa Ana CA 92701
714-558-8666
Fax 714-558-6966

1. **Our office charges for missed appointments.**

If you must cancel or reschedule your appointment, MDEyeCare requires that you do so at least 2 business days in advance.

Failure to do so will result in a $50 fee to be collected directly from the patient.

If there is a valid reason for a late cancellation, you will not be charged.

2. **Do you have an Advance Directive? We are required by federal mandate to collect this information.**

Please circle one of the following choices.

Yes No I do not know, or decline to say

What is an Advance Directive? *It is a written document that tells your health care providers who should speak for you and what medical decisions they should make if you become unable to speak for yourself.*

Patient Signature Date

_____ _____