WELCOME TO OUR OFFICE

Today's Date: ____________________

PATIENT INFORMATION

Last: ____________________
First: ____________ MI: ________
Patient's SSN: ____________________
Date of Birth: ____________ Age: ________
Gender: O **Male** O **Female**
Street: ____________________
City: ____________ State: ____ Zip Code: ________
Race: ____________ Ethnicity: ____________
Primary Language: O English O Other: ________
Home Phone: ( ) ____________________
Work Phone: ( ) ____________________
Email: ____________________
Cell Phone/ Primary Contact: ( ) ____________
Employer/School: ____________________
Occupation/Grade: ____________________
Spouse/Parent's Name: ____________________
Spouse/Parent's Work: ____________________

WHOM SHOULD WE NOTIFY IN CASE OF AN EMERGENCY?

________ ( ) ________
Name *Telephone* *Relationship*

What is the major purpose of this visit?

- ____________________

Any problems with your current contact lenses or glasses?

- ____________________

Interested in LASER Vision Correction?

- ____________________

VERY IMPORTANT!

Whom may we thank for referring you to our office?

O Current Patient: ____________________
O Referring Dr.: ____________________
Primary Care Physician or Other Medical Professional
O Referring OD.: ____________________
Optometrist
City: ____________ State: ________
O Name of friend or relative ____________

IF NOT REFERRED, HOW DID YOU CHOOSE OUR OFFICE?

O Insurance List
O Saw Sign/Building
O Newspaper/Radio/TV
O Yellow Pages: Which Directory?
O Web Page: Which Website?

At Inland Eye Specialists, we are professionals committed to providing you with the most comprehensive eyecare available in a respectful and compassionate atmosphere. We also promise to educate you thoroughly regarding your vision and eye health needs.

We are dedicated to actively advancing our knowledge and expertise in the field of eyecare so we can offer you leading-edge technology and products, thus maximizing your quality of life.

As a result of our united efforts, we will provide you with the highest level of service and value to ensure that our relationship with you, your family, and your friends lasts for many years to come.

INSURANCE INFORMATION

Vision Insurance: ____________________
Subscriber Name: ____________________
Subscriber SSN: ____________________
Subscriber Birth date: ____________________

Primary Medical Insurance ____________________
Subscriber Name ____________________
Subscriber SSN ____________________
Subscriber Birth Date ____________________

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MEDICAL OR VISION INSURANCE:

____
(SIGNATURE) (DATE)

PHYSICIAN & PHARMACY

Who is Your Primary Care Physician:

____
City ____________ Phone ( ) ________
Preferred Pharmacy____________________
Pharmacy Phone *(if known)* ( ) ____________

All Information Provided is Privileged & Confidential

INLAND EYESPECIALISTS

PATIENT HISTORY FORM

Patient Name: ______________________ Today's Date: ____________

Birth Date: ______________

A — PAST OCULAR HISTORY:

Have you been diagnosed with ANY eye problems?
(e.g. Cataracts, Glaucoma, Macular Degeneration, Retinal Problems, etc.)

▼ O Yes O No

Please list all OCULAR PROBLEMS:	Date	Left Eye/ Right Eye / Both?

B — PAST OCULAR PROCEDURES:

Have you had ANY ocular Surgeries or Procedures?
(e.g. Cataract Surgery, Glaucoma Surgery, Laser Surgery, LASIK, retinal Surgery, etc.)

▼ O Yes O No

Please list all previous OCULAR PROCEDURES:	Date	Left Eye/ Right Eye / Both?

C — PAST SYSTEMIC ILLNESSES:

Have you had ANY past systemic illnesses?
(e.g. Thyroid Problems, Diabetes, Hypertension, Heart Disease, Cancer, Respiratory Issues, ect.)

▼ O Yes O No

Please list ALL PAST MEDICAL ILLNESSES:

D — HEAD/OCULAR TRAUMA

Have you had ANY of the past head or ocular trauma?
(e.g. Falls, Head Concussions, Motor Vehicle Accidents, etc.)

▼ O Yes O No

Please list all PAST HEAD/OCULAR TRAUMA:	Date of injury

E — PAST BODILY SURGERIES

Have you had any general/bodily surgeries or procedures?
Please list ALL past surgeries

▼ O Yes O No

Please list all previous GENERAL SURGERIES:	Date of surgery

INLAND EYESPECIALISTS

F — FAMILY AND SOCIAL HISTORY

Does any of your family have ANY medical or eye diseases?
If YES, please note relationship to patient.

OD

Disease	Yes	No	Relationship
Macular degeneration	O	O	
Glaucoma	O	O	
Retinal problems	O	O	
Lazy eye	O	O	
Blindness	O	O	
Diabetes	O	O	
High blood pressure	O	O	
Heart disease	O	O	
Respiratory disease	O	O	
Cancer	O	O	
Thyroid/Autoimmune disease	O	O	

Follow Up Questions

Do you smoke? O Yes O No
If yes, how much? ____ packs per day?

Former smoker? O Yes O No

Do you drink alcohol? O Yes O No
If yes, how much? ____ drinks per day?

Comments:____

____

____

G — REVIEW OF THE SYSTEMS

Do you currently have any of the following problems?

	Questions	Yes	No	If YES, please explain
1.	Do you have any allergies to any medication?	O	O	
2.	Constitutional (Fever, weight loss, fatigue, other)	O	O	
3.	Eyes (Glaucoma, cataract, lazy eye, retina problems, other – please specify)	O	O	
4.	Ear | Nose | Mouth | Throat (hearing loss, sinus problems, sore throat, difficulty breathing)	O	O	
5.	Cardiovascular (heart problems, chest pain, irregular heart beat)	O	O	
6.	Respiratory (asthma, shortness of breath, wheezing , coughing)	O	O	
7.	Gastrointestinal (heartburn, abdominal pain, diarrhea, vomiting)	O	O	
8.	Genitourinary (urinary problems, blood in urine)	O	O	
9.	Integumentary (Skin rashes, excessive dryness)	O	O	
10.	Musculoskeletal (Muscle aches, joint pain, swollen joints)	O	O	
11.	Neurological (numbness, weakness, headaches, paralysis)	O	O	
12.	Hematologic/ Lymphatic (blood disorders, Leukemia)	O	O	
13.	Allergic/ Immunologic (hay fever, allergies)	O	O	
14.	Endocrine (thyroid problems, diabetes, Autoimmune disease)	O	O	

H — CURRENT MEDICATIONS

Are you currently taking ANY Medications or Vitamins/Supplements?
If Yes, please list all with included Milligrams and times per day if known:

Medication Name	Strength	Frequency Taken

Thank you!

MENIFEE VALLEY
OPTOMETRY

FINANCIAL POLICY

As stated in the Consumer Protection Act, Menifee Valley Optometry would like to inform you of our policies concerning the financial responsibilities you incur as a result of the treatment we provide you and your family.

1. You will be billed for any unpaid office visits and procedures. As a part of our service, we will submit insurance claims on your behalf, once you have provided the necessary information.

   Please Note:

   - Since your insurance is normally a contract between the insurance company and you or your policy holder, we are not part of that agreement. We will bill your insurance company as a courtesy. If it is determined that you are ineligible for benefits under your health plan or you receive non-covered and/or non authorized services, you will be responsible for payment. In some cases, we may have a specific contract with your PPO or HMO. You will be notified of those specific carriers. We will not change diagnoses to accommodate requests from your insurance carrier.
   - Our fees are usually covered up to the maximum paid by your insurance. Some insurers pay claims as a percentage, i.e., 50%, 80%, etc., of what they regard as the "Usual and Customary" charge for their plans. Our charges are considered appropriate for ophthalmology, optometry, medical eyewear and medical services in this area.

2. Please provide us with at least 24 hours notice if you are unable to keep your scheduled appointment to avoid a $25 no-show fee.
3. There will be a $25 charge on all returned checks.

TEST FOR EYEGLASSES/ REFRACTION

A test for eyeglasses is often performed during a yearly eye examination. If you have a vision plan with whom we are contracted and you are eligible for services under that plan, we will bill that plan for this examination.

If you have a test for eyeglasses (refraction) today, and you **DO NOT** have a vision plan, you will be charged a reduced fee of $65.00. **MEDICARE AND/OR YOUR MEDICAL INSURANCE WILL NOT COVER PAYMENT FOR THIS EXAMINATION.** If you **DO NOT** want a test for eyeglasses performed today, please inform our staff **BEFORE** you see the doctor.

____
Initial

CONTACT LENS EXAMINATIONS

If you are interested in receiving contact lens services, please read and initial below. If you have any questions, our opticians can explain related fees and any insurance benefits you may have.

An examination for contact lenses is done at the request of the patient (often during a yearly eye examination). This test, which includes the initial evaluation, lens fitting, any necessary training, and follow up visits for up to three months, is **SEPARATE FROM A ROUTINE EXAMINATION AND HAS A SEPARATE FEE.**

The amount of the fee is based upon the complexity of your case. For most patients, fees range between $79 and $189. Charges for custom or medically necessary contact lenses are higher and will be determined on a case by case basis. If you are unsure of what your financial responsibilities will be, please ask our staff or doctor **BEFORE** the contact lens examination is performed. I understand the above statement and agree to responsible for payment of this fee and any other non-covered services.

____
Initial

RELEASES

I understand and agree that I am responsible for all non- covered, non-authorized, and/or non-eligible charges pertaining to my medical care regardless of my insurance status. I have read the Financial Policy above and completed the patient information form. This information is true and correct to the best of my knowledge. I will notify you of any changes. I hereby authorize **Menifee Valley Optometry** to release any information requested by my insurance company, admitting hospital and/or referring physicians on my behalf or minor/dependent. I hereby assign payments received for medical services rendered to me and my family to **Menifee Valley Optometry**. I hereby authorize **Menifee Valley Optometry** to make complaints to the State Insurance Commissioner, the Health Care Financing Administration, or the Department of Labor on my behalf regarding my benefits claims.

Signed: ______________________ Date: ______________

(To be signed by patient or adult responsible for payment if patient is less than 18 years old)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Hemet	Murrieta	Menifee	Fallbrook	Laser Center
3953 W. Stetson Ave Hemet, CA 92545 (951) 652-4343	25395 Hancock Ave. Suite 100 Murrieta, CA 92562 (951) 698-5388	27168 Newport Road Suite 4 Menifee, CA 92584 (951) 679-0545	521 E Elder Street Suite 102 Fallbrook, CA 92028 (760) 728-5728	25460 Medical Center Dr. Suite 103 Murrieta, CA 92562 (951) 698-4575
David S McCleary, O.D., Privacy Officer Mark Nilsen, Security Officer	John J McDiarmid, O.D., Privacy Officer Mark Nilsen, Security Officer	Eric M. Fennema, O.D., Privacy Officer Mark Nilsen, Security Officer	J Grant Tew, M.D., Privacy Officer Mark Nilsen, Security Officer	Jonathan M Geller, O.D., Privacy Officer Mark Nilsen, Security Officer

I hereby acknowledge that a copy of Menifee Valley Optometry' Notice of Privacy Practices will be posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment. A copy of our most current Notice of Privacy Practices can be viewed on our website at www.inlandeyespecialists.com

Signed: ______________________ Date: ______________

Print Name: ______________________ Telephone: ______________

If not signed by patient, please indicate relationship below.

____ Parent or guardian of minor patient
____ Guardian or conservator of an incompetent patient
____ Beneficiary or personal representative of deceased patient

Name of Patient: ______________________

I AUTHORIZE THAT THE ABOVE INFORMATION BE RELEASED TO THE FOLLOWING:

Please check all that apply: ☐ Family Member(s) ☐ Insurance Company ☐ Doctor(s) ☐ Lawyer(s) ☐ Other
In the space provided, please list the name(s) and relationship of the person(s) authorized to receive this information.

1. Name______________________ Relationship______________________

2. Name______________________ Relationship______________________

3. Name______________________ Relationship______________________

Thank You!