PacificEyeMD.com
Phone: (800) 345-8979
Fax: (909) 949-3967

APPLE VALLEY
Medical Ophthalmology
15099 Kamana Rd.
Apple Valley, CA 92307

Surgery Center
16030 Kamana Rd.
Apple Valley, CA 92307

BARSTOW
Medical Ophthalmology
500 E. Mountain View St.
Barstow, CA 92311

COLTON
Ophthalmology Clinic and Surgery
1900 E. Washington St.
Colton, CA 92324
Phone: (909) 825-3425
Fax: (909) 825-4778

EASTVALE
Medical Ophthalmology
12442 Limonite Ave., Ste. 200
Eastvale CA 91752

HESPERIA
Medical Ophthalmology
11959 Mariposa Rd.
Hesperia, CA 92345

RANCHO CUCAMONGA
Medical Ophthalmology
8112 Milliken Ave., Ste. 203
Rancho Cucamonga, CA 91730

Dedicated LASIK Center
9481 Haven Ave., Ste. 200
Rancho Cucamonga, CA 91730
Phone: (909) 937-9230
Fax: (909) 937-9238

RIVERSIDE
Medical Ophthalmology
6216 Brockton Ave., Ste. 214
Riverside, CA 92506

TEMECULA
Medical Ophthalmology
41877 Enterprise Circle N., Ste. 110
Temecula, CA 92590

UPLAND
Ophthalmology Clinic and Surgery
555 & 591 N. 13th Ave.
Upland, CA 91786

Thank you for choosing Pacific Eye Institute!

Enclosed you will find our new Patient Paperwork Packet.

Please complete this packet before your appointment and bring the completed forms with you to the appointment.

Please bring a complete list of your current medications, your insurance card, and an identification card.

If you have a Power of Attorney, you will need to bring a copy with you as we will be required to add this to your file.

Your new patient appointment will last for approximately two hours. Because your eyes will be dilated during this appointment, please bring a driver with you.

Your appointment information:

DATE: _____

TIME: _____

LOCATION: _____

PROVIDER: _____

Please feel free to contact our office if you have any questions. We look forward to seeing you soon.

INLAND EYE LASIK

PATIENT INFORMATION

Today's Date: _____ Account Number: _____

Patient Name: _____
First *Middle* *Last*

Address: _____
Street *City* *State* *Zip*

Date of Birth: _____ Age: _____ Social Security Number: _____ ☐ MALE ☐ FEMALE

Preferred Phone: (_____) _____ ☐ Home ☐ Cell Secondary Phone: (_____) _____ ☐ Home ☐ Cell

Email: _____ Driver's License Number: _____

☐ Check here if you ***DO NOT*** consent to receiving email/text messages, including appointment reminder messages

I authorize the practice to disclose or provide Protected Health Information to me as described below. I understand that it is my responsibility to notify the practice of any change in this manner of communication. This authorization is in effect until a written notification of revocation is received:

☐ Preferred Phone ☐ Secondary Phone ☐ Email listed above ☐ Mailing Address listed above

Primary Care Physician Name: _____ Address: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ African American/Black
☐ White ☐ Native Hawaiian/Other Pacific Islander

EMERGENCY CONTACT

Name: _____ Relation: _____ Phone: _____

PREFERRED PHARMACY

Pharmacy: _____ Address: _____

RESPONSIBLE PARTY*

Name: _____ Relation: _____ Phone: _____

**Only complete this section if the patient is NOT the responsible party*

Address: _____
Street *City* *State* *Zip*

HOW DID YOU FIND US?

☐ Doctor: _____ ☐ Insurance Referral

☐ Internet/Online ☐ Friend/Family ☐ Social Media ☐ Advertisement/Other

MEDICAL INSURANCE

PRIMARY Insurance Co.: _____ Member ID: _____ Group/Policy No.: _____

Policy Holder Name/DOB: _____ Relation to Patient: _____

PRIMARY Insurance Co.: _____ Member ID: _____ Group/Policy No.: _____

Policy Holder Name/DOB: _____ Relation to Patient: _____

My signature below indicates the above information is correct and accurate to the best of my knowledge.

Name: _____ **Signature:** _____ **Date:** _____

Medical History Questionnaire

Patient Name: _____ **Patient Date of Birth**:_____
First *Middle* *Last*

Current Height: _____ **Current Weight**: _____ **Do you currently wear**: ☐ Glasses ☐ Contact Lenses

In your own words, please describe the reason for your visit with us today: _____
_____

Allergies | Please list all known allergies to medication (including intravenous and contrast dye and anesthetics), and environmental allergens (including seasonal, food, and latex). ☐ **Check here** if you have no known allergies

Allergy	Reaction	Allergy	Reaction

Current Medications | Please list all your current prescribed medications (including eye drops or medical cannabis), over-the-counter medications, vitamins, and/or supplements. ☐ **Check here** if you are not on any medications

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Symptoms Review | Please select below any symptoms you are experiencing:

☐ Reading small print ☐ Reading traffic or street signs ☐ Driving at night/in bright light
☐ Watching Television ☐ Floaters or flashers ☐ Difficulty seeing steps/curbs
☐ Glare or Halo ☐ Dry, red, sandy, or itchy feeling ☐ Other: _____

Medical History | Please check below if YOU are experiencing or have experienced any of the following:

Y	N	Constitutional	Y	N	Cardiovascular	Y	N	Endocrine	Y	N	Integumentary
		Fatigue			Chest Pain/Pressure			Cold/Heat Intolerance			Hives
		Fever			Irregular Heartbeat			Diabetes			Rash

Y	N	HEENT	Y	N	Gastrointestinal	Y	N	Neurological	Y	N	Musculoskeletal
		Bulging Eyes			Abdominal Pain			Imbalance			Back Pain
		Hearing Loss			Constipation/Diarrhea			Headache			Joint Stiffness
		Sinus Problems			Nausea/Vomiting			Memory Difficulty			Muscle Weakness

Y	N	Respiratory	Y	N	Hematologic	Y	N	Genitourinary	Y	N	Psychiatric
		Asthma			Bleeding			Pain with Urination			Depressed Mood
		Coughing			Bruising			Blood in Urine			Irritability
		Wheezing			Tender Lymph Nodes						

Past Ocular and Surgical History | Please check if <u>you</u> have received treatment (including eye drops and medical cannabis) or had surgery for any of the following conditions (note type):

Yes	No	Surgery and Type	Yes	No	Surgery and Type
☐	☐	Cataract: _____	☐	☐	Cornea: _____
☐	☐	Glaucoma: _____	☐	☐	LASIK: _____
☐	☐	Oculoplastic: _____	☐	☐	Retina: _____
☐	☐	Other: _____	☐	☐	Other: _____

Personal and Family Health History | Please check if you or a family member have/have had any of the following or please. Please check here if: ☐ NO RELEVANT PERSONAL HISTORY ☐ NO RELEVANT FAMILY HISTORY

	Self	Mother	Father	Sibling		Self	Mother	Father	Sibling
Allergies	☐	☐	☐	☐	Heart Disease	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	High Blood Pressure	☐	☐	☐	☐
Blindness	☐	☐	☐	☐	High Cholesterol	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	Lazy Eye	☐	☐	☐	☐
Corneal Disease	☐	☐	☐	☐	Macular Degeneration	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Migraines	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	Retinal Disease	☐	☐	☐	☐
Seizure Disorder	☐	☐	☐	☐	Stroke	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	Diabetes	☐	☐	☐	☐
Cancer, please note type(s): _____						☐	☐	☐	☐
Auto-Immune Disorder, please note type(s): _____						☐	☐	☐	☐
Other, please specify: _____						☐	☐	☐	☐
Other, please specify: _____						☐	☐	☐	☐

Other History

Females: Are you currently pregnant? ☐ Yes ☐ No Are you currently breastfeeding? ☐ Yes ☐ No

Have you ever used tobacco? ☐ Yes ☐ No IF YES: ☐ Former user ☐ Current use – daily ☐ Current use – occasional

Tobacco Product used: ☐ Cigarette ☐ Cigar/Cigarillo ☐ Pipe ☐ Snuff/Chew ☐ Smokeless ☐ Other: _____

Do you drink alcohol? ☐ Yes ☐ No IF YES, _____ drinks per: ☐ Day ☐ Week ☐ Month ☐ Year

Do you consume caffeine? ☐ Yes ☐ No IF YES: ☐ Coffee ☐ Energy drinks ☐ Soda ☐ Tablets ☐ Other: _____

Occupation: _____ Status: ☐ Full time ☐ Part Time ☐ Retired/Other

Informed Consent for Dilated Eye Examination

In the course of your care, whether today or in the future, it is important for the doctor to evaluate your retina, macula, and optic nerve by viewing the back part of your eye using a dilated examination. Dilating eye drops are used to enlarge the pupil of the eye to allow the physician to fully see these areas of your eyes.

Dilation frequently changes and/or blurs vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible to predict to what degree your vision will be affected. Driving may be difficult after the examination. If you are concerned about these problems, you may wish to make alternative transportation arrangements. Some patients do drive after dilation with the assistance of temporary sunglasses, which we will provide to you after your examination. Though rare, adverse reactions, such as a rise in eye pressures causing pain, may be triggered by the dilating drops. It may be necessary to lower this pressure by using eye drops, oral medication, and/or laser treatment. There is also the possibility of an allergic reaction to the dilating drops.

The decision to undergo dilation is yours. You may choose to not have the dilation performed; however our doctors recommend that dilation be performed to better examine your eyes for possible disease.

Your initials below indicates that you have read and understand the risks and benefits associated with the use of dilation drops to complete a dilation examination, and hereby authorize the Pacific Eye team to administer dilation drops and proceed with the dilated examination.

INITIALS: _____

My signature below indicates the above information is correct and accurate to the best of my knowledge.

Name: _____ Signature: _____ Date: _____

Financial Policy

Patient Name: _____ Patient Date of Birth: _____

Financial Policy and Outstanding Balances | The patient is responsible for payment of all charges associated with the patient's visit at Pacific Eye Institute (PEI) and all subsidiaries of Pacific Eye Institute. As courtesy and for your convenience, we will bill your insurance company if you have provided us with all the requested insurance information. You are responsible for your deductible, co-payment, co-insurance, and non-covered service(s) at the time the service(s) are rendered. If you are uncertain of your coverage, please contact your insurance company directly. If you choose not to bill your insurance company for care provided, it is understood that you assume financial responsibility for all charges. The patient agrees that in return for the services provided to the patient by PEI, the patient will pay the patient's account at the time service is rendered or will make financial arrangements satisfactory to PEI for payment. If an account is sent to an attorney for collection, the patient agrees to pay collection expenses and attorney's fees as established by the court and not by a jury in any court action. The patient understands and agrees that if the patient's account is delinquent, the patient may be charged interest at the legal rate. Patients who have outstanding balances will be billed monthly. All balances are due 30 days from the billing statement date and must be paid prior to any future services being rendered.

Payment Methods Accepted | We accept cash, check, and most major credit cards (Visa, MasterCard, American Express, Discover, etc.) and CareCredit. There is a $25 fee for all returned checks.

Assignment of Benefits | 1 – Medicare: I request that payment of authorized Medicare benefits be made on my behalf to Pacific Eye Institute (PEI), for services furnished to me by PEI. 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 CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. PEI accepts the charge determination of the Medicare carrier as the full charge, and I am only responsible for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier. **2 – MediGap**: I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to PEI if possible, or otherwise, me.

Release of Information | Pacific Eye Institute (PEI) may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable under contract to PEI for reimbursement for services rendered, and (2) any healthcare provider for continued patient care. PEI may also disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute, or regulation. A copy of this authorization may be used in place of the original.

Other Insurance | I understand that Pacific Eye Institute (PEI) maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that PEI has no contract, either expressed or implied, with any plan that does not appear on that list. The patient or patient's responsible party agrees that they are individually obligated to pay the full charges of all services rendered to the patient by PEI if the patient belongs to a plan that does not appear on the above-mentioned list.

Non-Covered Services | I understand that Pacific Eye Institute's (PEI) contracts with health care service plans (i.e. HMO', PPOs) relate only to items and services which are covered by the health care service plans. Accordingly, the patient or patient's responsible party accepts full financial responsibility for all items or services which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care plan furnishes to the patient, and treatment or tests not authorized by the health care service plan. The patient or patient's responsible party agrees to cooperate with PEI to obtain necessary health care service plan authorizations.

My signature below indicates my full understanding of, and agreement with, this financial policy

Patient or Responsible Party Signature: _____ Date: _____

Privacy Practices and Release of Information

Privacy Practices
Pacific Eye Institute's Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI). The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Acknowledgement. The terms of our Notice may change. If we change our notice, you may receive a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment, or healthcare operations. The law does not require Pacific Eye Institute to agree to this restriction, but if we do, we shall honor that agreement.

I acknowledge that I have been made aware of Pacific Eye Institute's privacy practices, which is posted in the waiting room. I understand that a copy of the Notice of Privacy Practices is available upon my request.

By signing this form, you consent to our use and disclosure of Protected Health Information (PHI) about you for treatment, payment, and healthcare operations. You have the right to revoke this Acknowledgement. Any revocation must be in writing and signed by you. Such revocation will not affect any disclosures we have already made in reliance on your prior Acknowledgement. Pacific Eye Institute provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Release of Information
I authorize the Pacific Eye Institute to release my Protected Health Information (PHI) to the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Important Information
You have the right to terminate this authorization at any time by submitting a written and signed notice to our office. The revocation takes effect once it is received by our office, and does not apply to actions already taken before the revocation is received. You have the right to receive a copy of your signed authorization upon your request. Your signature below confirms your authorization and your understanding of this policy and your rights.

Open Payments Database Notice

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

Patient Name: _____ Patient Date of Birth: _____

Patient/Responsible Party Signature: _____ Date: _____