Sierra Eye Medical Group
Registration Materials

The following documents are included for you to consider and / or fill out:

- Patient Registration Form
- Financial Disclosure Document
- Medical History Form
- Acknowledgement of Notice of Privacy Practices (NPP)
  (To view our NPP, go to www.sierraeye.com and follow the links)

Please fill out the applicable forms completely. Upon completion, please do one of the following:

FAX to (559) 636-3937

or

Mail to:

New Patient Registration
Sierra Eye Medical Group, Inc.
2830 West Main Street
Visalia, CA 93291-4300

or

Bring the forms with you on your first visit

If you need directions to our office, please go to www.sierraeye.com and follow the links to the direction page.

Thank you for choosing Sierra Eye Group for your eye care.

REGISTRATION FOR SIERRA EYE MEDICAL GROUP, INC.

Are you a new patient in this office? ❑ Yes ❑ No

Name of patient _____
First Middle Last

Patient's mailing address _____
Street No. City State Zip

Patient's street address _____
Street No. City State Zip

❑ Male
❑ Female Phone No. _____ Age _____ Birth date _____ Patient's SSN _____

Patient's Race _____ Ethnicity: Hispanic or Non-Hispanic Preferred Language _____

Father's name _____ Father's SSN _____

Father's employer _____ Father's occupation _____

Employer's address _____ Phone No. _____

Mother's name _____ Mother's SSN _____

Mother's employer _____ Mother's occupation _____

Employer's address _____ Phone No. _____

Referred by _____

Do we have your permission to thank the person who referred you? ❑ Yes ❑ No

Patient's family physician _____

PERSON RESPONSIBLE FOR PAYMENT

Name _____ SSN _____

Address _____
Street No. City State Zip

INSURANCE INFORMATION

Name of insurance company _____ Policy# _____

Insured party name _____

Insured party DOB _____ Insured party SSN _____

FINANCIAL AGREEMENT, AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I authorize treatment of the person named above and agree to pay all fees and charges for such treatment. I agree to pay all charges for me and members of my family shown by statements, promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. In the event legal action should become necessary to collect an unpaid balance due for medical services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the Court determines proper.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to Sierra Eye Medical Group, Inc. where applicable, but without their assuming responsibility for the collection thereof. I authorize payment of medical benefits to Sierra Eye Medical Group, Inc. I authorize the release of any medical information necessary to process claims. This agreement remains valid until revoked in writing by me. A copy of this agreement is as valid as the original.

NOTICE: Do not sign this agreement before you read and agree to the conditions set forth on the reverse side.

Signature _____ Date _____

SIERRA EYE GROUP
SIERRA EYE MEDICAL GROUP, INC.
2830 WEST MAIN STREET
VISALIA, CALIFORNIA 93291
TELEPHONE (559) 636-1000

Name: _____ Date: ____/____/____

Your personal physician: _____

List any drug allergies and reactions:

	Drug	*Reaction*
1)	_____	_____
2)	_____	_____
3)	_____	_____

List any present medication you use:

	Name		*Name*
1)	_____	6)	_____
2)	_____	7)	_____
3)	_____	8)	_____
4)	_____	9)	_____
5)	_____	10)	_____

List any present health problems *(such as high blood pressure, diabetes, or heart trouble)*:

1) _____
2) _____
3) _____
4) _____
5) _____

List any major surgeries you have had:

	Surgery Type	*Year*
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____

Over ☛

Family and Personal Health History Review & Inventory

PERSONAL SYSTEM REVIEW

Please check every box that applies to you.

Do the following run in your family?

- ❒ Lazy eye (Amblyopia)
- ❒ Blindness
- ❒ Cataracts
- ❒ Crossed eyes
- ❒ Diabetic retinopathy
- ❒ Glaucoma
- ❒ Macular degeneration
- ❒ Cancer
- ❒ Diabetes
- ❒ Heart Disease
- ❒ High blood pressure
- ❒ Stroke
- ❒ Other familial disease

Your Social History

- ❒ Smoke ___packs/day X ___yrs
- ❒ Alcohol___drinks/day X ___yrs
  - ❒ rarely
  - ❒ only socially
- ❒ Not driving ❒ Driving
- ❒ Driving with limitations
- ❒ Live alone
- ❒ Live with spouse or companion
- ❒ Live with adult child
- ❒ Live in assisted care facility
- ❒ Live in nursing home
- ❒ Live at home with care giver

Your occupation:

_____

Comments:

Constitutional

- ❒ Recent or recurrent fever?
- ❒ Recent weight loss?
- ❒ Recent weight gain?
- ❒ _____

Eyes

- ❒ Blurred vision?
- ❒ Double vision?
- ❒ Glare?
- ❒ _____

Ears, Nose, Throat

- ❒ Hearing loss?
- ❒ Sinus problems?
- ❒ _____

Cardiovascular

- ❒ Chest pain?
- ❒ Irregular heart beat?
- ❒ Heart failure?
- ❒ High blood pressure?
- ❒ Slow hear rate?
- ❒ Past coronary artery angioplasty?
- ❒ Past coronary artery stent(s)?
- ❒ Past open heart surgery?
- ❒ _____

Respiratory

- ❒ Shortness of breath?
- ❒ Wheezing?
- ❒ Asthma?
- ❒ Coughing up blood?
- ❒ _____

Gastrointestinal

- ❒ Abdominal pain?
- ❒ Nausea?
- ❒ History of hepatitis?
- ❒ History of stomach or colon cancer?
- ❒ _____

Genitourinary

- ❒ Blood in urine?
- ❒ If female: unexpected bleeding?
- ❒ _____

Musculoskeletal

- ❒ Joint pain?
- ❒ Low back pain?
- ❒ Arthritis?
- ❒ Gout?
- ❒ _____

Integumentary/Skin/Breast

- ❒ Rosacea?
- ❒ Have you had breast cancer?
- ❒ Have you had skin cancer?
- ❒ _____

Neurological

- ❒ Numbness?
- ❒ Weakness?
- ❒ Have you ever had a TIA?
- ❒ Have you ever had a stroke?
- ❒ Have you ever had CT scan of head?
- ❒ Have you had MRI scan of head?
- ❒ _____

Psychiatric

- ❒ Anxiety?
- ❒ Depression?
- ❒ _____

Endocrine

- ❒ Diabetes?
- ❒ Thyroid problem?
- ❒ Ever consulted an endocrinologist?
- ❒ _____

Hematologic/Lymphatic

- ❒ Anemia?
- ❒ Blood disorder?
- ❒ Unusual bleeding?
- ❒ Are you taking anticoagulants?
- ❒ _____

Allergic/Immunologic

- ❒ History of hives?
- ❒ Hay fever?
- ❒ Seasonal allergies?
- ❒ _____

Please add any comments that would be helpful to know more about your health:

Acknowledgement of Receipt of Notice

Sierra Eye Medical Group, Inc. (SEMG) &

Sierra Ambulatory Surgery Center, A Medical Corporation (SASC)

2828 - 2830 W. Main St., Visalia, CA 93291-4300

Privacy Officials:

Deborah Navarrette Phone (559)636-1000 ext.225

Rita Gomez Phone (559) 734-7272

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices

The most current Notice of Privacy Practices is on our website www.sierraeyegroup.com

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

Account #_____

If not signed by the patient, please indicate your relationship to the patient:

- ❑ parent or guardian of minor patient
- ❑ guardian or conservator of an incompetent patient
- ❑ beneficiary or personal representative of deceased patient

Name of Patient: _____

Account #_____

***For Office Use Only*:**

- ❑ Signed form received by: _____
- ❑ Acknowledgment refused:

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____