

REGISTRATION FOR SIERRA EYE MEDICAL GROUP, INC.

(for office use only)

ARE YOU A NEW PATIENT IN THIS OFFICE?  YES  NO ACCT# \_\_\_\_\_

CHART# \_\_\_\_\_

NAME OF PATIENT \_\_\_\_\_

PATIENT'S MAILING ADDRESS FIRST MIDDLE LAST \_\_\_\_\_

PATIENT'S STREET ADDRESS STREET NO. CITY STATE ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

MALE  FEMALE AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ SOCIAL SECURITY \_\_\_\_\_

PATIENT'S RACE \_\_\_\_\_ ETHNICITY: Hispanic or Non-Hispanic PREFERRED LANGUAGE \_\_\_\_\_

OCCUPATION \_\_\_\_\_ DRIVER LIC OR ID \_\_\_\_\_

EMAIL \_\_\_\_\_

EMPLOYER NAME AND ADDRESS \_\_\_\_\_

SINGLE  MARRIED  WIDOWED  DIVORCED  SEPARATED

REFERRED BY \_\_\_\_\_

DO WE HAVE YOUR PERMISSION TO THANK THE PERSON WHO REFERRED YOU?  YES  NO

FAMILY PHYSICIAN \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ SPOUSE'S OCCUPATION \_\_\_\_\_

EMPLOYER OF SPOUSE \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER'S ADDRESS \_\_\_\_\_

IN CASE OF AN EMERGENCY:

CONTACT NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

HOME PHONE NO. \_\_\_\_\_ WORK PHONE NO. \_\_\_\_\_

PERSON RESPONSIBLE FOR PAYMENT

NAME \_\_\_\_\_

INSURANCE INFORMATION

MEDICARE# \_\_\_\_\_  MEDI-CAL  PRIVATE INSURANCE  VISION PLAN

NAME OF COMPANY \_\_\_\_\_ POLICY# \_\_\_\_\_

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 statement 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 \_\_\_\_\_

RESPONSIBLE PERSON

STEVEN M. CANTRELL, M.D.  
MATTHEW G. KIRKMAN, M.D.  
DAVID T. STARK, M.D., Ph.D.  
MICHELLE C. CANTRELL, O.D.  
LAUREN V. FERNANDEZ, O.D.



## SIERRA EYE GROUP

SIERRA EYE MEDICAL GROUP, INC.  
2830 WEST MAIN STREET  
VISALIA CALIFORNIA 93291  
TELEPHONE (559) 636-1000  
FAX (559) 636-3937

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name of your personal physician or clinic you attend: \_\_\_\_\_

### MEDICAL HX

- Borderline Diabetes
- Diabetes
- Gestational Diabetes, Unspecified
- High Blood Pressure
- Hyperlipidemia
- Thyroid Disease
- Graves' Disease
- Heart Disease
- Heart Attack
- Transient Ischemic Attacks (TIA)
- Stroke in Brain
- Aneurysm
- Anemia
- Sleep Apnea, Unspecified
- Cancer
- BPH (Enlarged Prostate)
- Multiple Sclerosis
- Myasthenia Gravis
- Plaquenil (Hydroxychloroquine) Use
- Ankylosing Spondylitis
- Crohn's Disease
- Arthritis
- Rheumatoid Arthritis
- Systemic Lupus Erythematous
- Sarcoidosis
- Ulcerative Colitis
- Polymyalgia Rheumatica
- Ehlers-Danlos Syndrome
- Marfan's Syndrome
- Autism
- Dementia
- Hard of Hearing

### Surgical HX

- None
- Amputation
- Angioplasty
- Appendectomy
- Back Surgery
- Bariatric Surgery
- Brain Shunt
- C-Section
- Cardiac Surgery
- Colon Resection
- Foot Surgery
- Gallbladder
- Gastric Bypass
- Hand Surgery
- Heart Bypass
- Heart Stent
- Hernia Surgery
- Hip Replacement
- Hysterectomy
- Knee Surgery
- Mastectomy
- Pacemaker
- Shoulder Surgery
- Thyroidectomy
- Tonsillectomy

### Common Drug Allergy

- No Known Drug Allergies
- Phenylephrine
- Anesthetic
- Sulfa
- Penicillin
- Amoxicillin
- Aspirin
- Sudafed
- Codeine
- Morphine

- Steroids
- Alphagan
- Azopt
- Beta Blockers
- Brimonidine
- Cosopt
- Ciprofloxacin
- Latanoprost
- Tobramycin

### Allergy to substance

- Latex
- Fluorescein Dye
- ICG Dye
- Iodine
- Tape
- Pollen
- Dust
- Mold
- Mildew

### Food Allergy

- Shellfish
- Dairy
- Eggs
- Peanuts
- Strawberries
- Gluten
- Lactose
- Soy

### FAMILY HX

- Adopted/Unknown
- Noncontributory
- Macular Degeneration
- Glaucoma
- Cataract
- Blindness
- Lazy Eye (Amblyopia)
- Strabismus

\*\*see other side\*\*

- Color Blindness
- Retinitis Pigmentosa
- Uveitis
- Cancer
- Diabetes
- Heart Disease
- Hypertension
- Kidney Disease
- Thyroid Disease
- Stroke

## Family and Personal Health History

### Review & Inventory

PERSONAL SYSTEM REVIEW  
YOUR MEDICAL HISTORY

#### YOUR SOCIAL HISTORY

##### Smoking/Tobacco

- Never Smoker
- Former Smoker
- Current Ever Day Smoker
- Current Some Day Smoker
- Heavy Tobacco Smoker
- Light Tobacco Smoker
- Unknown If Ever Smoked

##### Marital Status

- Married
- Single
- Divorced
- Widowed
- Separated
- Partner
- Unknown

##### Alcohol

- None
- Occasional/social
- 1-2 Drinks/day
- 3-4 Drinks/day

#### Driving

- Yes
- No

#### Living Conditions

- Lives alone
- Lives with spouse
- Lives with family
- Lives with Other
- Live with caretaker
- Lives in nursing home

#### Occupation

- Retired
- Unemployed
- Working
- Not Working
- Disabled
- Student
- Homemaker

#### Fall Risk

- Yes
- No

#### Constitutional

- Fever
- Weight loss
- Fatigue

#### HENT

- Hearing loss
- Dry Mouth
- Sinus Infections
- Sore Throat
- Runny Nose
- Ear Ache
- Jaw Claudication

#### Cardiovascular

- Blood Pressure Stable per Patient.
- Blood Pressure Uncontrolled per Patient
- Chest pain
- Irregular Heart Beat
- Shortness of Breath
- Shortness of Breath when Laying Flat
- Swelling of the Feet
- Racing Pulse

#### Respiratory

- Asthma
- Emphysema
- COPD
- Wheezing
- Cough
- Coughing up Blood
- Severe or Frequent Colds
- Difficulty Breathing

#### Gastrointestinal

- Jaundice or Yellow Skin
- Diarrhea
- Constipation
- Acid Reflux
- Trouble Swallowing
- Abdominal pain
- Nausea

#### Genitourinary

- Blood in urine
- Pain/Burning on Urination
- Dialysis
- Kidney Failure
- Kidney Problems
- Kidney Stones

#### Musculoskeletal

- Muscle Aches
- Joint Stiffness
- Joint pain
- Low Back Pain
- Difficult Laying Flat due to Musculoskeletal Discomfort
- Back Pain while Sleeping or Awakening

#### Integumentary/Skin/Breast

- Rash
- Skin Cancer
- Skin Sores
- Severe Itching
- Loss of Hair

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Please add any

**comments that would be  
helpful to know more about  
your health:**

### Neurological

- Stroke
- Numbness
- Weakness
- Headaches
- Scalp Tenderness
- Seizures or Convulsions
- Fainting
- Dizziness
- Paralysis of Extremities
- Tremor

### Psychiatric

- Anxiety
- Depression

### Endocrine

- Blood Sugars Stable Per Patient
- Blood Sugars Poorly Controlled Per Patient
- Patient Unsure of Glycemic Control
- Excess Thirst
- Excessive Urination
- Heat Intolerance
- Cold Intolerance
- Hair Loss
- Dry Skin

### Hematologic/Lymphatic

- Anemia
- Easy Bleeding
- Easy Bruising
- Prolonged bleeding

### Allergy/Immunology

- Autoimmune Disease
- Seasonal allergies

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## PATIENT FINANCIAL AGREEMENT

### PLEASE READ THOROUGHLY AND SIGN ON BACK PAGE

In consideration of receiving services from Sierra Eye Medical Group, Inc., you agree:

1. All services are provided to you with the understanding that you are responsible for the cost regardless of your insurance coverage. If you would like to know the cost of a service, please inquire prior to treatment. Please be aware that not all services are a covered benefit with different insurance companies. You are responsible for knowing what services are or are not covered. **KNOW YOUR BENEFITS.**
2. **Upon check-out**, we will collect your deductible, co-pay, and payment for any uncovered services as well as the patient's portion as determined by insurance. We accept cash, check, and credit cards: Master Card, Visa, Discovery, and American Express.
3. Your insurance policy is a contract between you and the insurance carrier. We are NOT a party to that contract. **It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Failure to provide all required information may necessitate patient payment for all charges.**
4. We will bill your insurance company once as a courtesy, but you are still ultimately responsible for payment of all services you receive. If your insurance company does not respond within 30 days we will follow up with an inquiry on your behalf. If, however, your insurance does not respond within 60 days of claim submission, a statement will be sent to you. You should call your insurance to question why the claim is not paid. Our office will assist you only after you have contacted your insurance.
5. If your medical claim has not been paid and your insurance company has not resolved your dispute you may register a complaint with the Department of Insurance. Our office will do everything we can to assist you, however; you must understand you cannot delay payment while you are awaiting the outcome of your complaint.
6. Any unpaid charges over 90 days old will turn to outside collection agency with additional collection agency fees. You are responsible for any collection fees, legal fees, or court costs incurred in the collections process. This agency will report your failure to pay to the THREE (3) national credit reporting agencies.
7. Due to large volume of cancelled appointments, there will be a minimum charge of \$50.00 if the office is not notified one business day prior to the appointment date, so please contact the office during business hours of 8:00 am to 5:00 pm if you should need to cancel.

No show patients will also be charged a fee of \$50.00.

**\*\*See other side\*\***

If you are scheduled for any surgical procedure, please note, we require at least 72 hours (3 business days) notice to either cancel or reschedule your procedure so that we can schedule another patient in your appointment slot.

A notice of less than 72 hours (3 business days) will result in a \$100 cancellation fee.

**After Hours Calls:**

We have a doctor on-call 24/7. If you call after hours you will be subject to a \$25-\$100 fee, which is not covered by your insurance.

Remember, these charges are not billable to your insurance company; this is your full responsibility.

8. Returned checks are subject to a \$50.00 return check fee.

We do understand that temporary financial problems may affect timely payment. We encourage you to communicate any such problems so that we can assist you in the management of your account.

\_\_\_\_\_  
**Patient Signature (or parent / guardian of minor child)**

\_\_\_\_\_  
**Date**

Copy / Declined Copy of Patient Financial Agreement

Initials: \_\_\_\_\_



## 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 Official:**

**Deborah Navarrette (SEMG & SASC) – Phone (559) 636-1000, Ext. 225**

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](http://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 # \_\_\_\_\_

I authorize \_\_\_\_\_ (Relation) \_\_\_\_\_ (DOB) \_\_\_\_\_

access to all my Patient Health Information (excluding): Please specify \_\_\_\_\_

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### For Office Use Only:

Signed form received by: \_\_\_\_\_

Acknowledgement refused:

Efforts to obtain:

\_\_\_\_\_

Reasons for refusal:

\_\_\_\_\_