Walnut Creek Eye Care

1844 San Miguel Dr. Ste 303 Walnut Creek, CA 94596
(925) 930-8100

Patient name: _____
(LAST) (FIRST) (MIDDLE)

Date of birth _____Cell phone:_____Home phone:_____

Age:_____SSN_____-_____-_____ Marital status: Married / Single

Home address: _____

City:_____State:_____Zip code:_____

E-Mail address:_____Preferred language:_____

Referring Physician:_____Primary Care Physician:_____

Race:_____Ethnicity:_____ Sex:_____

Primary medical insurance:_____

Secondary medical insurance:_____

Vision plan: VSP MES Other:_____

Preferred Pharmacy: _____

Name of Spouse/Partner/Responsible party if minor:_____

Spouse DOB:_____Spouse SSN_____-_____-_____Spouse Phone:_____

Address (if different from yours)_____

_____

Emergency contact:_____
(NAME) (PHONE) (RELATIONSHIP)

Please select your preferred methods of communicating your protected health information:

▢ Do not leave a message other than to return a call.
▢ Leave results and messages on answering machine or voicemail.

Other persons authorized to receive my medical information:

Name:_____Phone: _____Relationship:_____

General Health History:

▢ Diabetes	▢ Thyroid disease	▢ HIV	▢None
▢ High cholesterol	▢ Heart attack	▢ Asthma	
▢ Stroke	▢ Cancer	▢ TB	
▢ High blood pressure	▢ Lung problems	▢ Bleeding problems	

Eye Health History:

▢ Macular degeneration	▢ Diabetic retinopathy	▢ Eye Surgery	▢None
▢ Glaucoma	▢ Retinal detachment	▢ Eye trauma	
▢ Cataract			

Do you smoke? YES NO

How many alcoholic drinks do you have per week? _____

Did you get your flu shot this year? YES NO If so, when?_____

Any falls in the last 6 months? YES NO If so, when?_____

Family Eye History:

▢ Macular degeneration ▢ Diabetic retinopathy ▢ Glaucoma ▢ None

Please list any medications with their doses you are currently taking:

_____
_____
_____
_____

Medication allergies:_____

Responsibility of Payment Acknowledgment:

I acknowledge that if Walnut Creek Eye Care **is not** in network with my medical/vision insurance provider, I agree to pay all fees associated with my visits to Walnut Creek Eye Care. If Walnut Creek Eye Care **is** In-Network with my insurance provider, I agree to pay all associated fees that are not paid by my insurance such as but not limited to: Deductibles that have not been met, termination of coverage at time of visit, and failure to provide accurate primary or secondary insurance information, resulting in non-payment. I understand that not providing accurate and up-to-date insurance information delays claim processing and may result in nonpayment once the correct insurance is billed due to "timely filing". If this is the case, I will be responsible for all fees associated with my visit. I acknowledge that I have examined my own insurance card and if ***John Muir Physicians Network*** or ***John Muir Medical Group*** is written on my card, I will be responsible for the cost of my visit, as Walnut Creek Eye Care does not accept this insurance due to frequent claim denials. I acknowledge that if my insurance requires a referral to be seen, for example, if I have an **HMO** or **EPO** insurance, insurance will not pay for my visit unless a referral is received by Walnut Creek Eye Care from my primary care physician prior to my visit. It is my responsibility to know whether or not my insurance requires a referral and to have the referral sent to Walnut Creek Eye Care prior to my visit. If no referral is received by Walnut Creek Eye Care prior to my visit, I will be responsible for all fees associated with my visit. I understand that referrals expire and sometimes there is a limit to the number of visits that will be covered by my insurance. It is my responsibility to ensure that my referral has not expired and that I have not surpassed the number of visits my referral allows for. Otherwise, I will be responsible for all fees associated with my visit.

Acknowledgement of Receipt of Privacy Practices and Medical Board Notice:

I hereby acknowledge that I have read this medical practice's *Notice of Privacy Practices*. I further acknowledge that a copy of the current notice is posted in the reception area, and that I will be offered a copy of any amended *Notice of Privacy Practices* at each appointment. Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov, or call (800) 633-2322.

Acknowledgement of Scheduling, Cancellation, and No-Show Policies:

I hereby acknowledge that Walnut Creek Eye Care charges a fee of up to $100 in order to schedule an appointment at our office after not showing up to an appointment, canceling an appointment less than 1 **business day** (24 hours) prior to the appointment time, or arriving too late to an appointment to be seen. I acknowledge that there is a $250 fee for surgeries canceled or rescheduled less than 1 month in advance. I authorize Walnut Creek Eye Care to send email, text, and/or automated phone reminders for appointments.

By signing this form I acknowledge and agree to all above policies:

Signature: _____

Print Name: _____

Date: _____

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

▢ Parent or guardian of minor patient ▢ Guardian or conservator of an incompetent patient