Mosier
EYE CENTER

Dear Patient,

Welcome to Mosier Eye Center! We appreciate your selection of our office and we look forward to serving you for all your eye care needs. This packet was created to provide you with some valuable information regarding your upcoming visit. Please review this letter and take a moment to complete the **new patient forms**. It is essential to bring the items listed below to your appointment. We realize that your time is valuable and completing these forms in advance will save you time in our office.

Please bring:

- Photo ID
- Medical insurance cards and vision insurance information (if applicable)
- Out-of-pocket financial responsibilities (i.e. copay, deductible, co-insurance, etc.)
- New patient packet (enclosed)
    - Patient Registration Form
    - Medical History Form
    - Patient Consent of Privacy Practices
- Current glasses/contact lens boxes, vials or past prescription (if applicable)
- Medical records from former eye doctor (if applicable)

If you have a list of medications, please bring it with you and we can make a photocopy. Otherwise, list medicines on the **medical history form** in the provided line.

Appointments usually take 1½ - 2 hours. As part of a thorough exam, your eyes will be dilated, unless medically contraindicated. Most people are able to drive following dilation. If you have experienced problems in the past or if your eyes have never been dilated, you may want to bring a driver. You will experience light sensitivity and difficulty with close-up work following dilation. The dilation will wear off in approximately 2-5 hours.

If the patient is under 18 years old, a parent or legal guardian must be present at the initial appointment. A waiver may be signed for subsequent visits.

Our office is located at 265 Laguna Road in Fullerton. We are near the cross street of Bastanchury and Laguna Road. You will find our office north of Bastanchury, past the Wells Fargo bank on the right hand side.

We look forward to seeing you.

William D. Mosier, M.D.
John J. Kim, M.D.
Jamie L. Hancock, O.D.
Yanna Yu, O.D.

PATIENT INFORMATION FORM

PATIENT NAME Last	First	MI
ADDRESS	DATE OF BIRTH	GENDER ☐ **M** ☐ **F**
CITY/STATE/ZIP	MARITAL STATUS	
CELL PHONE	SOCIAL SECURITY NUMBER	
HOME PHONE	PRIMARY LANGUAGE	
WORK PHONE	OCCUPATION	
EMAIL	EMPLOYER	

ETHNICITY	☐ Hispanic	☐ Non- Hispanic	☐ Decline to Answer
RACE	☐ Asian ☐ White	☐ Amer. Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander	☐ Black/African Amer. ☐ Decline to Answer

PRIMARY CARE PHYSICIAN / ADDRESS

/

EMERGENCY CONTACTS (At least one)

NAME _____ PHONE _____ RELATIONSHIP _____

NAME _____ PHONE _____ RELATIONSHIP _____

PRIMARY INSURANCE _____ ID / Policy #	**SECONDARY** INSURANCE _____ ID / Policy #

VISION INSURANCE _____

ID / Policy #

If policy subscriber / guarantor is other than the patient (minor):

NAME PHONE RELATIONSHIP

How were you referred to our practice?

☐ PRIMARY CARE PHYSICIAN	☐ OPTOMETRIST _____
☐ INTERNET	☐ INSURANCE
☐ FAMILY/FRIEND _____	☐ OTHER: _____

MOSIER EYE CENTER ~ Patient History Questionnaire

IMPORTANT: This questionnaire if to be reviewed at each appointment. **Please answer all questions**.

PATIENT DEMOGRAPHICS

Name: _____ DOB: _____ Phone: _____
Emergency Contact: _____ Phone: _____
Primary Physician _____ Phone: _____
Last Seen _____

MEDICAL/EYE INFORMATION

How is your general health? _____ Do you have problems with any of these systems?

Gastrointestinal	Yes / No	Nervous	Yes / No	Endocrine (glands)	Yes / No
Ears/Nose/Throat	Yes / No	Urinary	Yes / No	Blood/Lymph	Yes / No
Cardiovascular	Yes / No	Muscles/Bones	Yes / No	Allergic/Immunologic	Yes / No
Respiratory	Yes / No	Eyes	Yes / No	Headaches	Yes / No
High Blood Pressure	Yes / No	Mental	Yes / No	Integumentary (skin)	Yes / No

Diabetes: Yes/No Type: _____ Date of Diagnosis: _____ Date of last tetanus shot: _____

Cholesterol: Yes / No Smoking: Current / Former / Never Alcohol: Social / Never

Allergies to Medication:_____

Do you take blood thinners? Yes / No Specify: Coumadin Plavix Aspirin Aggrenox Pradaxa
Other: _____

Current Medications: _____
(If necessary please use next page)

Other Health problems: _____

Do you have any eye conditions/problems? Yes / No Explain_____

Have you had any eye operations? Yes / No Kind: _____When?_____

Have you had any other operations? Yes / No Kind: _____ When? _____

DO YOU HAVE:

Glaucoma	Yes / No	Cataracts	Yes / No	Dry Eyes	Yes / No
Macular Degeneration	Yes / No	Retinal Detachment	Yes / No	Blurred Vision	Yes / No
Wear Glasses	Yes / No	Wear Contact Lenses	Yes / No	Type _____	

FAMILY HISTORY

High Blood Pressure	Yes / No	Relation _____	Glaucoma	Yes / No	Relation _____
Macular Degeneration	Yes / No	Relation _____	Cataracts	Yes / No	Relation _____
Retinal Detachment	Yes / No	Relation _____	Diabetes	Yes / No	Relation _____

DOCTOR USE ONLY

Notes:

Reviewed by: _____ Date:_____
Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____
Reviewed by: _____ Date: _____

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Please list your current medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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PATIENT RESPONSIBILITY

Agreement of Responsibility

I understand that professional services are rendered to the patient and that the patient is responsible for charges incurred for these services. Payment for annual deductibles and co-insurance may be collected at the time of service. I understand that I am financially responsible for charges not covered by my insurance company.

_____
Patient Initial

Consent to Treatment

I voluntarily consent to such care and treatment as prescribed by the physician as is necessary in his/her judgment.

_____
Patient Initial

Release of Information/ Assignment of Benefits

I authorize use of this form on all my insurance submissions and authorize release of information to process a claim to all my insurance companies. I permit a copy of this authorization to be used in place of the original. I authorize the provider to act as my agent in helping me obtain payment from my insurance companies I understand the provider does not accept responsibility for collecting my insurance claims or for negotiating a settlement on disputed claims. I assign all rights and claims for reimbursement of expenses allowable under my insurance plan and authorize payment directly to the provider for services rendered. I understand I will receive a monthly statement for any balance due from me.

_____
Patient Initial

I have read and fully understand the above statements.

_____
Patient Signature/Parent for minor

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PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.
I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow- up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Please fill out this form and email it to "new@mosiereyecenter.com" or print it out and mail it in to: Mosier Eye Center 265 Laguna Road, Fullerton, CA 92835 before your appointment. Thank you.