Pabalan Eye Center

6900 Brockton Ave. Ste 203 Riverside, Ca 92506

Please complete the enclosed forms prior to your appointment and bring them with you on_____ for your _____ appointment.

PLEASE ARRIVE FIFTEEN MINUTES PRIOR TO APPOINTMENT TIME

In addition to your completed forms, bring the following to your appointment:

1. Insurance card
2. Picture I.D. with current address
3. Current pharmacy name, address and phone number.
4. Co-payment or Deductible (payment is due at time of service).
5. If you are a new patient, please bring a driver. Your eyes may be dilated.
6. A list of all your medications.
7. Prescription eye drops

We accept the following forms of payment:

- Cash
- All major credit cards and Care Credit
- Checks

Appointment length varies by doctor and medical condition. Please be prepared to spend between 1 and 3 hours in our office.

If you arrive without insurance information, you will be responsible for payment at the time of service.

If you are unable to keep this appointment, please call our office at least twenty four hours in advance. We understand that delays can happen, however we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time, we will have to reschedule the appointment, if prior notice of possible delay is not given. Our office number is (951)682-4353.

P A B A L A N E Y E C E N T E R

Please Turn Off Your Cell Phone/Por Favor Apague su Celular

PATIENT INFORMATION/INFORMACION DEL PACIENTE:

Mr. / Mrs. / Ms. / Miss / Dr. or Military Rank _____ Branch of Service: USAF / USMC / USA / USN / USCG

Name/Nombre: _____ /_____/_____

FIRST/PRIMER MI LAST/APELLIDO

Home Phone/Numero De Teléfono (____)_____ Cell Phone/Celular: (____)_____

Home Address/Dirección: _____City/Ciudad:_____

State /Estado: ____ Zip/Código Postal:_____

Email Address/Correo Electrónico:_____

Social Security Number/Seguro Social: ____-____-_____ Date of Birth/Fecha de Nacimiento: _____/_____/_____

Marital Status/ Estado Matrimonial: Single/Soltero Married/Casado Divorced/Divorciado Widowed/Viudo

Who is your regular Medical Doctor or PCP/Doctor Primario: _____

Driver's License # and State:/ Numero de licencia y Estado:_____

Parent (Padre) / Guardian / Power of Attorney (Poder Legal): _____

Ocupation/ Ocupación:_____

Who may we contact in case of emergency/A quien contactamos en caso de una Emergencia?_____

Phone/Numero de Teléfono: _____

To whom we may release information about you/ A quién podemos comunicar información sobre usted?

1)_____ Relationship/Relación:_____

2)_____ Relationship/Relación:_____

3)_____ Relationship/Relación:_____

RESPONSIBLE PARTY/INDIVIDUO RESPNSABLE: **Who is responsible for payment of your bill/ Quien es responsable de pagar la cuenta? (Circle "MYSELF" if applicable/ circule "YO" si aplica) MYSELF/ YO**

Name/Nombre: _____ / _____ / _____

FIRST/PRIMER MI LAST/APELLIDO

Their relationship to you/La relación de ellos a usted:_____

RESPONSIBLE PARTY'S INSURANCE INFO/INFORMACION DE SEGURANZA:

Primary Insurance/Seguranza Primaria:_____

*Secondary Insurance/Seguranza Secundaria::*_____

Subscriber Name/Nombre de el Suscriptor: _____

Subscriber's Date of Birth/Fecha de Nacimiento de Suscriptor: _____

Responsable Party is responsible for payment if insurance is not covered. /El Suscriptor o el individuo responsable es responsable de cualquier cobro si la seguranza no cubre.

NOTIFY US OF ANY CHANGE TO INSURANCE PLAN OR COVERAGE*/Notifiquenos si cambia de seguranza*

PHARMACY INFORMATION/INFORMACION DE SU FARMACIA:

Name and Address/Dirección y Nombre _____:

OFFICE POLICIES:

Our doctors can provide your care only after you have reviewed office policies and signed these forms. Thank you.

- **Cell phone use is not allowed inside the office.** Please step outside if you must use your phone.
- ***Patient or Responsible Party must know their Insurance Benefits and Coverage, whether a referral is required, and if Pre-Certification is needed for procedures or surgery.***
- ***NOTIFY US IMMEDIATELY OF ANY CHANGE TO INSURANCE PLAN OR COVERAGE.***

CANCELLATION OR FAILURE TO SHOW FOR APPOINTMENTS

If you need to cancel an appointment, we require **notification at least 24hrs prior** to the appt time. Failure to give adequate notice or to keep your appointment will result in a **Cancellation/ No Show fee** charge of $30.00. We understand that delays can happen however we must try to keep the other patients and doctors on time. If a patient is **15 minutes past their scheduled time we may have to reschedule** the Appointment if prior notice of possible delay were not given.

A.) REFILLING OF PRESCRIPTION MEDICATIONS:

All medication refill requests are to be made in a timely manner. Please do not wait until you are out of drops or medicines! Our office will comply with your request in a timely manner but processing your request can take up to 72 hrs. Certain medications require monitoring, if you do not keep appointments we may not be able to refill your medications until you have been seen by our office.

X_____ DATE_____

Patient / Guardian Signature

B.) ASSIGNMENT AND RELEASE:

I, the undersigned, have insurance coverage with the above named insurance(s) and assign directly to Dr. Pabalan all medical benefits, if any, otherwise payable to me for services rendered. I understand that I bear final responsibility for all charges. I understand that insurance does not pay for all costs, even for some care that you and your doctor may decide is needed.

For all reasonable costs of collection if my account becomes delinquent, I hereby authorize the doctor to release all information necessary to get payment of benefits. I authorize the use of this signature on all my insurance submissions, paper or electronic.

X_____ DATE_____

Signature of Insured / Guardian

C.) MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Pabalan.

I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. 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 HCFA-1500, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

X_____ DATE_____

Medicare Beneficiary Signature

D.) NOTICE OF PRIVACY PRACTICES (HIPAA) INFORMATION

I, the undersigned, hereby acknowledge that I have been given access to a copy of the Notice of Privacy Practices. The Notice of Privacy Practices is available online at www.pabalaneyecenter.com and you have the right to obtain a paper copy of this notice from us by request, even if you have agreed to accept this notice electronically. Furthermore, I understand that my information will not be released or sold, under any circumstances. My information, including that which pertains to medications or appointments WILL NOT be shared with others, including family members, unless I have listed them on the front of the form. Please direct any questions to our Privacy Officer, Francisco J. Pabalan, M.D. at 951-682-4353 or email at ivcmain@yahoo.com.

X_____ DATE_____

Patient/ Guardian Signature

E.) PERMISSION TO LEAVE MESSAGES VIA EMAIL, TEXT OR PHONE:

I, the undersigned, grant permission to Pabalan Eye Center to do its best to leave messages and information for me, including messages regarding my medical care, and appointments, by Email, Text, or Phone.

F.) ATTENDANT / RESPONSIBLE PARTY:

Attendant or responsible party is required to remain with the patient at all times and throughout the exam.

HOWEVER, AS A COURTESY TO OTHER PTS, WE ASK THAT NO MORE THAN ONE PERSON ACCOMPANY THE PATIENT WHILE IN THE WAITING ROOM OR EXAM ROOM.

I understand the policies above and wish to receive services from Pabalan Eye Center.

X_____ DATE_____

Patient/ Guardian Signature

PabalanEyeCenter

NAME/ NOMBRE:_____

WHO IS YOUR GENERAL MEDICAL DOCTOR/ DOCTOR PRIMARIO?_____

WHY ARE YOU BEING SEEN TODAY? (DESCRIBE YOUR EYE PROBLEM)/ EL MOTIVO DE SU VISITA:

_____

_____

PLEASE CIRCLE YES OR NO ON ALL OF THE FOLLOWING MEDICAL PROBLEMS/CIRCULE SI O NO SI TIENE ALGUNA DE ESTAS CONDICIONES

STROKE/ EMBOLIO	YES/ SI	NO	HEART DISEASE/ PROBLEMAS DEL CORAZÓN	YES/ SI	NO
MIGRANE/ MIGRAÑA	YES/ SI	NO	ANEMIA	YES/ SI	NO
LIVER DISEASE/ ENFERMADAD DE EL HIGADO	YES/ SI	NO	HIGH BLOOD PRESSURE/ALTA PRESIÓN	YES/ SI	NO
ALLERGIES/ ALERGIAS	YES/ SI	NO	HIGH CHOLESTEROL/ COLESTEROL ELEVADO	YES/ SI	NO
DEPRESSION/ DEPRESIÓN	YES/ SI	NO	KIDNEY DISEASE/ PROBLEMAS DE LOS RIÑÓNES	YES/ SI	NO
ASTHMA/ ASMA	YES/ SI	NO	HIV (AIDS)/ VIH	YES/ SI	NO
CANCER	YES/ SI	NO	DIABETES HOW LONG/ CUANTO TIEMPO?_____	YES/ SI	NO
TYPE/TIPO	_____		ARE YOU ON INSULIN/ USA INSULINA? A1C _____	YES/ SI	NO

ARE YOU PREGNANT/ ESTA EMBARAZADA? (WOMAN/MUJER) YES/ SI NO

OPERATIONS OR SERIOUS INJURIES/ CIRUGÍAS:

DATE/ FECHA	REASON/ RAZON:
_____	_____
_____	_____
_____	_____
_____	_____

Any Other Illness or Medical Information:
Alguna otra enfermedad o información médica:

_____
_____
_____
_____

HAVE YOU EVER HAD CATARACT SURGERY? RIGHT EYE ____ DATE: _____ LEFT EYE ____ DATE _____
AH TENIDO CIRUGÍA DE CATARATAS? OJO DERECHO____ FECHA:_____OJO IZQUIERDO____ FECHA_____

PLEASE CIRCLE ANY OF THE FOLLOWING EYE CONDITIONS YOU HAVE EXPERIENCED/ POR FAVOR CIRCULE CUALQUIERA DE LAS SIGUIENTES CONDICIONES DE OJOS QUE HA EXPERIMENTADO

RETINAL DETACHMENT/ DESPRENDIMIENTO DE RETINA	YES/ SI	NO	RETINAL SURGERY/ CIRUGÍA DE LA RETINA	YES/ SI	NO
GLAUCOMA	YES/ SI	NO	DRY EYE/ OJO SECO	YES/ SI	NO
GLAUCOMA SURGERY/ CIRUGÍA DE GLAUCOMA	YES/ SI	NO	STYES/ PERILLA	YES/ SI	NO
CATARACTS/ CATARATAS	YES/ SI	NO	CROSSED EYES/ STRABISMO	YES/ SI	NO
MACULAR DEGENERATION/ DEGENERACIÓN MACULAR	YES/ SI	NO	EYE INJURY/ ACIDENTE AL OJO	YES/ SI	NO
LASER SURGERY/ CIRUGÍA DE LASER	YES/ SI	NO			

DO YOU HAVE ANY OF THE FOLLOWING EYE SYMPTOMS/TIENE ALGUNO DE ESTO SINTOMAS:

BURNING/ARDOR	YES/SI	NO	REDNESS/OJO ROJO	YES/SI	NO
SANDY/ARENOSO	YES/SI	NO	ITCHING/ COMESON	YES/SI	NO
MUCOUS DISCHARGE/LAGANA	YES/SI	NO	TIRED EYES/ OJO CANSADO	YES/SI	NO

HAVE YOU EVER USED/AH USADO:

ALCOHOL	YES/SI	NO	FREQUENCY/FRECUENCIA_____
TOBACCO	YES/SI	NO	FREQUENCY/FRECUENCIA_____
DRUGS/ DROGAS	YES/SI	NO	FREQUENCY/FRECUENCIA_____

HAVE ANY FAMILY MEMBERS EVER HAD (WRITE DOWN IF APPLICABLE):

ALGUNO DE SUS FAMILIARES AH TENIDO (ANOTE SI APLICA) :

Cataracts/Cataratas _____ Hereditary Eye Problems/problemas de los ojos hereditarios _____

Glaucoma _____ Crossed/Turned Eyes / strabismus _____

Macular Degeneration/Degeneración macular_____ Diabetes _____

Retinal Detachment/desprendimiento de la retina_____

CURRENT MEDICATIONS MEDICAMENTOS:	**DOSAGE DOSIS:**	**ALLERGIC REACTION TO ANY MEDICINE(S)?WHAT REACTION? ALERGIAS A MEDICINAS?**
_____	_____	
_____	_____	
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Do you use Aspirin, Plavix, Coumadin or other blood thinner/toma algún adelgazante de la Sangre? YES/SI NO
*Have you ever had an allergic reaction to latex/Es alérgico(a) El latex ? YES/SI NO

GOVERNMENT REQUIRED QUESTIONS (PLEASE CIRCLE ONE OF THE FOLLOWING):

Do you identify as/Se identifica Como: **Male/Hombre** , **Female/Mujer**, **or Choose Not to Disclose**

Sexual Orientation/Orientación sexual: **Straight** , **Gay** , **Bisexual** , **Lesbian** , **or Choose Not to Disclose**