



**Kings Eye Center Medical Group, Inc.**

1395 W. Lacey Blvd. • Hanford, CA 93230 • Phone (559) 585-3937 • Toll Free (800)675-8088 • Fax (559)582-3645  
www.kingseyecenter.com

Patient Name \_\_\_\_\_ " \_\_\_\_\_"  
First Initial Last Nickname

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Mailing Address \_\_\_\_\_

Male  Female  City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Social Security Number **\*\*please give to the receptionist\*\*** Married  Single  Other  \_\_\_\_\_

Email Address \_\_\_\_\_ Preferred Language \_\_\_\_\_

Employer \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Address Phone Number

Emergency Contact \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Emergency Home Phone (\_\_\_\_) \_\_\_\_\_ Emergency Cell Phone (\_\_\_\_) \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ City/Location \_\_\_\_\_

**PLEASE PRESENT ALL MEDICAL, VISION, AND PRESCRIPTION INSURANCE CARDS ALONG WITH YOUR PHOTO ID.**

Primary Insurance Subscriber \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Drivers License Number \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Address Phone Number

Secondary Insurance Subscriber \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Drivers License Number \_\_\_\_\_

Mailing Address (if different from above) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Address Phone Number

I authorize payment of my medical/vision benefits by my insurance company to the provider..... (INITIALS) \_\_\_\_\_

I authorize the release of any medical/vision information necessary to process any of my claims..... (INITIALS) \_\_\_\_\_

I recognize that I am financially responsible for all charges incurred at Kings Eye Center. All costs must be paid the day services are rendered, unless arranged in advance, or if my insurance is one with which Kings Eye Center is contracted and rendered services are a covered benefit of my insurance plan ..... (INITIALS) \_\_\_\_\_

Responsible Party Signature

Date

**Bradley A. Beard, MD**

**Ronald S. Keck, OD**

**Stacy R. Omon, OD**

**Nathan Panttaja, OD**

**KINGS EYE CENTER CONSENT AGREEMENT**

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND /OR HEALTHCARE OPERATIONS**

I understand that as part of my healthcare, Kings Eye Center originates and maintains records describing my health history, symptoms, examinations, test results, diagnoses, slides, photos, treatment, personal data and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information for billing purposes
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality patient care and management by healthcare professionals

I understand and have been offered and/or provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Kings Eye Center reserves the right to change the notice and practices and will notify me of any revised notice. I understand that I have the right to the use of my health information. I also understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Kings Eye Center has already taken action in reliance thereon.

I consent to information regarding my healthcare treatment and confidential medical records to be released to the following people:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

I request the following restrictions to the use or disclosure of my health information: \_\_\_\_\_

I do not wish to have my information released to anyone.

Patient Name (please print) \_\_\_\_\_

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

Signature of Patient or Legal Representative Witness\*

*(This consent valid for 6 years from date of signature)*

\*To be signed by all adult patients or legal representative and kept in patient chart.

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Phone (559)585-3937 Toll Free (800)675-8088 Fax (559)582-3645

**Please bring your current glasses or contact lenses and  
your current medications to this appointment.**

## TO OUR PATIENTS:

Refraction is the process of determining the eye's refractive error, or need for glasses and/or contact lenses. It is an essential part of most eye examinations. This service is **NOT** a benefit covered by Medicare or Medi-cal, and most other medical insurance plans.

Our office fee for a refraction is **\$75.00**. This fee will be due and payable at the time of the visit, in addition to any insurance co-payment and/or share of cost amount.

## ACKNOWLEDGEMENT:

I have read the above information and understand the refraction is not covered by Medicare or Medi-cal, and most other medical insurance plans. I accept full financial responsibility for the cost of this service. The co-payment and/or share of cost amount is separate from and not included in the refraction fee.

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Signature of Patient/Responsible Party

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Date

\*This form shall remain in effect unless/until revoked in writing.

01/22/2023

**KINGS EYE CENTER MEDICAL GROUP, INC  
MEDICATION LIST**

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

**Please provide us with a list of all prescription and nonprescription medications you are currently taking.**

Medication name	Dose (mg, tsp, etc.)	How often do you take it?

**Allergies to Medications:**

Medication Name	Type of Reaction (rash, breathing difficulties, etc.)