20/20 Vision Care

Dr. Jaime Hall-Malouf

# MEDICAL HISTORY

Date ____/____/_____

## PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Email _____

Emergency Contact _____ Phone _____ Relationship _____

Social Security # _____ DOB _____ Age _____ Sex : Male/Female

Driver's License # _____ Marital Status: Single ____ Married ____ Divorced ____ Widowed ____

## RESPONSIBLE PARTY *Must be completed if patient is a minor.* PCP Phar #

Last Name _____ First Name _____ MI _____

Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Email _____

Social Security # _____ DOB _____ Relationship _____

## INSURANCE INFORMATION *Is Patient Primary on Policy Y/N, If yes, do not fill out this section.*

Do you have medical insurance? Yes/No Do you have vision insurance? Yes/No

Primary Insurance Company _____ Policy # _____

Policy Holder _____ Relationship _____

Social Security # _____ DOB _____ Sex : Male/Female

Secondary Insurance Company _____ Policy # _____

## EMPLOYMENT INFORMATION FOR PATIENT or RESPONSIBLE PARTY

Employer _____ Occupation _____

Student: Full time/Part time

How did you hear about us? Friend/Family _____ Yellow Pages _____ Signs _____

Insurance _____ Doctor _____ Other _____

When was your last eye exam? _____ Do you wear: Contacts Y/N Glasses Y/N

Are you interested in contacts? Y/N

## REVIEW OF SYSTEMS *Do you currently, or have you ever had, any problems in the following areas,* please check the applicable:

| | Yes | No |
|---|---|---|
| Constitutional: | | |
| Fever, weight loss/gain | ___ | ___ |
| Integumentary: Skin | ___ | ___ |
| Neurological: | | |
| Headaches | ___ | ___ |
| Migraines | ___ | ___ |
| Seizures | ___ | ___ |

| | Yes | No |
|---|---|---|
| Ear, Nose, Mouth, Throat: | | |
| Allergies/Hay Fever | ___ | ___ |
| Sinus Congestion | ___ | ___ |
| Runny Nose | ___ | ___ |
| Post-nasal drip | ___ | ___ |
| Chronic Cough | ___ | ___ |
| Dry Throat/Mouth | ___ | ___ |

| | Yes | No |
|---|---|---|
| Eyes: Loss of Vision | ____ | ____ |
| Blurred Vision | ____ | ____ |
| Distorted Vision/Halos | ____ | ____ |
| Loss of Side Vision | | |
| Double Vision | ____ | ____ |
| Dryness | ____ | ____ |
| Mucous Discharge | ____ | ____ |
| Redness | ____ | ____ |
| Sandy or Gritty Feeling | ____ | ____ |
| Itching | ____ | ____ |
| Burning | ____ | ____ |
| Foreign Body Sensation | ____ | ____ |
| Excess Tearing/Watering | ____ | ____ |
| Glare/Light Sensitivity | ____ | ____ |
| Eye Pain or Soreness | ____ | ____ |
| Chronic Infection | ____ | ____ |
| Sties or Chalazion | ____ | ____ |
| Flashes/Floaters | ____ | ____ |
| Endocrine: Thyroid/other glands | ____ | ____ |
| Allergic, Immunologic | ____ | ____ |
| Psychiatric: | ____ | ____ |

| | Yes | No |
|---|---|---|
| Respiratory: | | |
| Asthma | ____ | ____ |
| Chronic Bronchitis | ____ | ____ |
| Emphysema | ____ | ____ |
| Vascular/Cardiovascular: | | |
| Diabetes | ____ | ____ |
| Heart Pain | ____ | ____ |
| High Blood Pressure | ____ | ____ |
| Vascular Disease | ____ | ____ |
| Gastrointestinal: | | |
| Chronic Diarrhea | ____ | ____ |
| Chronic Constipation | ____ | ____ |
| Genitourinary: | | |
| Genitals/Kidney/Bladder | ____ | ____ |
| Bones, Joints, Muscles | ____ | ____ |
| Rheumatoid Arthritis | ____ | ____ |
| Muscle Pain | ____ | ____ |
| Joint Pain | ____ | ____ |
| Lymphatic, Hematologic: | | |
| Anemia | ____ | ____ |
| Bleeding Problems | ____ | ____ |

Please list any other conditions not listed that you have been diagnosed with or being treated for:

_____

_____

Do you have any allergies: If yes, specify:

_____

_____

Do you or anyone in your family have any of the above conditions?

_____

_____

List all medications that you are taking, include over the counter and home remedies:

_____

_____

_____

_____

Are you pregnant or nursing: Y/N

SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you use tobacco products? Y/N If yes, type/amount/how long _____

Do you drink alcohol? Y/N If yes, type/amount/how long _____

Do you use illegal drugs? Y/N If yes, type/amount/how long _____

Have you ever been exposed to or infected with: Gonorrhea ____ Hepatitis ____ HIV ____ Syphilis ____ TB ____

***We perform a yearly dilated exam on all patients, especially if you have any of the above conditions. Dilation last about 3 hours and the side effects are blurred vision at near and sensitivity to sunlight.***

_____ **I refuse dilation of my eyes today.**

# 20/20 Vision Care

*Quality Eye Care You Can Count On!*

**Dr. Jaime Hall-Malouf**

**Therapeutic Optometrist**

140 W. James St Wills Point, TX 75169 · (903)873-5757 · FAX (903) 873-5522

ADDITIONAL TESTING OFFERED BY 20/20 VISION CARE

We value your eye health and because these tests can add up quickly, we are offering.....

ALL TESTING TODAY FOR $120 (over $50 in savings)

**DIGITAL RETINAL IMAGING and OCT:** (2 test for the price of 1) This is improved technology in which Dr. Malouf can take high-resolution digital photography of the external and internal portion of your eye. Optical Coherence Tomography is the latest in eye technology, very similar to an ultrasound. We will be able to see beneath the surface and early detect many diseases that may not be seen with the naked eye or detected from other testing. This testing allows our office to obtain a baseline for comparison for future visits and is the best way to monitor ocular health.
THIS TEST IS AN ADDITIONAL $99

_____Yes, please do testing _____ No, do not do testing

**VISUAL FIELD:** Our office takes pride in providing the most advanced professional services and highest quality eye care. We are proud to have a state of the art computerized instrument that aids us in the early detection of many sight threatening eye diseases such as glaucoma, retinal disorders, and optic nerve anomalies; as well as tumors and lesions of the brain's visual pathway. Dr. Malouf highly recommends this test for all patients as part of their comprehensive visual analysis.
THIS TEST IS AN ADDITIONAL $79

_____ Yes, please do testing _____No, do not do testing

_____

PATIENT SIGNATURE DATE

_____

WITNESS DATE

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## PAYMENT, RETURN & COLLECTIONS POLICY

It is our office's policy that no merchandise leaves our office without first being paid for in full. This includes frames, lenses, contact lenses, supplements. accessories, and medications. All exam co-pays are to be paid in full at the time of your visit, without exception. If these are not paid for in full and merchandise is dispensed, please be advised you will be billed for the balance due on your account. If this balance is not settled in a timely manner, you will be sent to collection. If you cannot pay for your merchandise in full, we do accept half-down as an acceptable arrangement. Half of your total charges for the glasses/contact lenses AND your exam fees will be accepted and the other half will be taken at the time you pick up your merchandise.

It is our policy that no refunds are processed for returns due to buyer's remorse, so please be sure that you are satisfied with your selections of both frame and lenses before you finalize your purchase. You will not be able to return them should you decide that you do not like them. Please also be aware of the fact that we are happy to make any changes needed in regards to your prescription, but due to the nature of our relationship with our manufacturer, we cannot return nor refund them. We have a non-adapt policy that extends the full year of the prescription. If you cannot adapt to the particular lens you selected (i.e, You wanted to try a non line bifocal but could not adjust to the design), we will replace your lenses in a more suitable design. There is no refund for non-adapt, and there is no cost to you for the replacement.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by phone number, which could result in charges to you. We may also contact you by sending text messages or emails, using any numbers or emails you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing service, as applicable. I have read this disclosure and agree that the Creditor may contact me.

## FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS

In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payer benefits for medical or health care services payable to me, payable to 20/20 Vision Care. I certify that the information I have provided in connection with any application for payment by third party payers is correct. I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by mv insurance company and agree to make payments as requested by 20/20 Vision care.

ATTN: PLEASE BE ADVISED IT IS YOUR FINAL RESPONSIBILITY TO MAKE SURE YOU ARE USING A PARTICIPATING PROVIDER OF YOUR INSURANCE. IF YOUR INSURANCE DOES NOT PAY, YOU ARE RESPONSIBLE!

## CONSENT TO TREAT AND PRIVACY POUCY

I voluntarily consent to receive medical and health care services provided by 20/20 Vision Care, employees and such associates, assistants, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, exams, and treatment. I acknowledge that no warranty or guarantee has been made to me as to the result care. I understand that this consent to treatment will be valid and remain in effect as long as I am a patient of Dr. Jaime Malouf unless revoked in writing by me. I have received and read the HIPAA policy and understand that this act protects the privacy of all my medical records.

PAYMENT DUE WHEN SERVICES ARE RENDERED, PROFESSIONAL. FEES ARE NON-REFUNDABLE, GLASSES EXAM FEES DO NOT INCLUDE A CONTACT PRESCRIPTION.

_____

SIGNATURE DATE

_____

WITNESS DATE