20/20 Vision Care

Dr. Jaime Hall-Malouf

MEDICAL HISTORY

PATIENT INFORMATION Date___/___/___

Last Name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Phone – Home_____ Work_____ Cell_____

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

Drivers License #_____ Marital Status: Single____ Married____ Divorced____ Widowed____

RESPONSIBLE PARTY ***must be completed if patient is a minor.***

Last Name_____ First Name_____ MI_____

Address_____ City_____ State_____ Zip_____

DOB:_____ Social Security #_____ Relationship_____

Phone – Home_____ Work_____ Cell_____

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_____

DOB_____ Sex: Male/Female Social Security #_____

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_____

Emergency Contact_____ Phone_____ Relationship_____

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	___	___

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

		Yes	No			Yes	No
Eyes:	Loss of Vision	___	___	Respiratory:			
	Blurred Vision	___	___		Asthma	___	___
	Distorted Vision/Halos	___	___		Chronic Bronchitis	___	___
	Loss of side Vision	___	___		Emphysema	___	___
	Double Vision	___	___	Vascular/Cardiovascular:			
	Dryness	___	___		Diabetes	___	___
	Mucous Discharge	___	___		Heart Pain	___	___
	Redness	___	___		High Blood Pressure	___	___
	Sandy or Gritty Feeling	___	___		Vascular Disease	___	___
	Itching	___	___	Gastrointestinal:			
	Burning	___	___		Chronic Diarrhea	___	___
	Foreign Body Sensation	___	___		Chronic Constipation	___	___
	Excess Tearing/Watering	___	___	Genitourinary:			
	Glare/Light Sensitivity	___	___		Genitals/Kidney/Bladder	___	___
	Eye Pain or soreness	___	___		Bones, Joints, Muscles	___	___
	Chronic Infection	___	___		Rheumatoid Arthritis	___	___
	Sties or Chalazion	___	___		Muscle Pain	___	___
	Flashes/Floaters	___	___		Joint Pain	___	___
Endocrine: Thyroid/other glands		___	___	Lymphatic, Hematologic:			
	Allergic, Immunologic	___	___		Anemia	___	___
	Psychiatric:	___	___	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

ADDITIONAL TESTING PROVIDED BY 20/20 VISION CARE

WE VALUE YOUR EYE HEALTH AND BECAUSE THESE TESTS CAN ADD UP QUICKLY, WE ARE OFFERING....

ALL 3 TESTS TODAY FOR $110 ($69 SAVINGS)

DIGITAL RETINAL IMAGING: THIS IS AN IMPROVED TECHNOLOGY IN WHICH DR. MALOUF CAN TAKE HIGH-RESOLUTION DIGITAL PHOTOGRAPHS OF THE EXTERNAL AND INTERNAL PORTIONS OF YOUR EYE. THIS GREATLY AIDS IN THE ABILITY TO ACCURATELY DIAGNOSE AND DOCUMENT DISEASES OF THE EYE. IT ALLOWS OUR OFFICE TO OBTAIN A BASELINE FOR COMPARISON FOR FUTURE VISITS AND IS THE BEST WAY TO MONITOR THE OCULAR HEALTH. **THIS TEST IS AN ADDITIONAL $79**

PLEASE INITIAL ONE: _____YES, PLEASE TAKE PHOTOS TODAY.
_____NO, DO NOT TAKE PHOTOS TODAY.

VISUAL FIELD: OUR OFFICE TAKES PRIDE IN PROVIDING THE MOST ADVANCED PROFESSIONAL SERVICES AND THE HIGHEST QUALITY EYE CARE. WE ARE PROUD THAT WE 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 STRONGLY RECOMMENDS THIS TEST FOR ALL PATIENTS AS A PART OF THEIR COMPREHENSIVE VISUAL ANALYSIS. **THIS TEST IS AN ADDITIONAL $50**

PLEASE INITIAL ONE: _____YES, PLEASE PERFORM A VISUAL FIELD TODAY.
_____NO, DO NOT PERFORM A VISUAL FIELD TODAY.

OCT: OPTICAL COHERENCE TOMOGRAPHY IS THE LATEST IN EYE TECHNOLOGY, VERY SIMILAR TO AN ULTRASOUND. IT ALLOWS DR. MALOUF TO SEE BENEATH THE SURFACE AND EARLY DETECT MANY DISEASES THAT MAY NOT BE SEEN WITH THE NAKED EYE OR DETECTED FROM OTHER TESTING. THE HEALTH OF YOUR EYES MATTERS TO YOU AND IT MATTERS TO US TOO, WHICH IS WHY WE ARE OFFERING THIS PROCEDURE TO ALL OF OUR PATIENTS. IT IS A PAINLESS AND HIGHLY ADVANCED SCREENING SYSTEM THAT CHECKS FOR MANY POTENTIALLY SERIOUS CONDITIONS. **THIS TEST IS AN ADDITIONAL $50**

PLEASE INITIAL ONE: _____YES, PLEASE PERFORM THE OCT TODAY.
_____NO, DO NOT PERFORM AN OCT TODAY.

_____
PATIENT SIGNATURE DATE

_____
WITNESS SIGNATURE 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 that 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 collections. If you cannot pay for you rmerchandise 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 he 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 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 lense you selected (i.e. You wanted to try a noline bifocal but could not adjust to the design), we will replace your lenses in a more suitable design. There is no refund for a non-adapt, and there is no cost for the replacement.

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

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 amoungt to be paid or actually paid by my 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 RESPONSIBLY!

CONSENT TO TREAT AND PRIVACY POLICY

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, examinations, and treatment. I acknowledge that no warrany or guarantee has been made to me as to 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 by me in writing.

I have received and read the HIPAA policy and understand that this act protects the privacy of all y medical records.

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

_____ _____

Signature **Date**

_____ _____

Witness **Date**