New Patient Information

Legal Name:____ **Preferred name:**____________________
DOB:_______________________________
Billing Address:__________________________________ **Cell Phone: (_____)**__________________
____ **Home Phone: (______)**________________
City, State, Zip:__________________________________ **Other: (______)**_______________________
Email:____**Occupation:**__________________________
Preferred Method of Contact (circle one): **Cell Phone** **Home Phone** **Text Message** **Email**

Do you wear glasses? _____________ **Contacts?**____________ **if so what brand?**_______________

Please check any condition(s) that apply to YOU:

☐ Diabetes ☐ Cataracts ☐ Glaucoma ☐ Macular Degeneration ☐ Eye Surgery ☐ Eye Injury
☐ Pregnant ☐ Thyroid ☐ High Blood Pressure ☐ Heart Conditions ☐ Frequent Headaches
☐ Turned or Lazy Eye Other:____
☐ Current (everyday) Smoker ☐Current (someday) Smoker ☐ Former Smoker ☐ Never Smoker

Primary Care Physician:_______________________ **Preferred Hospital:**________________________
Preferred Pharmacy:__________________________

Please note any family history (parents, grandparents, siblings and/or children; maternal or paternal; living or deceased) for the following conditions:

DISEASE/CONDITION	YES	RELATIONSHIP TO YOU
Diabetes	☐	______________________
Cataracts	☐	______________________
Glaucoma	☐	______________________
Macular Degeneration	☐	______________________
Eye Surgery	☐	______________________
Eye Injury	☐	______________________
Thyroid	☐	______________________
High Blood Pressure	☐	______________________
Heart Conditions	☐	______________________
Frequent Headaches	☐	______________________
Turned or Lazy Eye	☐	______________________
Any other conditions:	☐	______________________

Please list any known drug allergies:
____
____

Please list your current prescribed medications:____

____

____

____

The Commission to End Health Care Disparities recommends that all practices collect certain basic demographic information on each patient served to help monitor quality of care. To the best of your ability please complete the following:

Preferred Language: ☐ English ☐ Spanish ☐ Other **Race:** ☐ White ☐ Black or African American ☐ Asian ☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander

Ethnicity ☐ Hispanic or Latino ☐ Non- Hispanic or Latino

Height: _______ft. ________in Weight: _______lbs.

Wellness Retinal Scan

A Wellness Scan is a non-invasive scan of the eye that can assist in the early detection of Glaucoma, Macular Degeneration and Neurological disorders (Aneurysms, and Optic Nerve Disease).

The recommended guideline for a Wellness Screening is any patients age 18 years and older every year with your regular exam

Please note, insurance does not cover this test, patients are responsible for the charge.

☐ YES, I do want the Wellness Retinal Scan Fee $30

☐ NO, I do not want the Wellness Retinal Screening

Please Read:

Dr. Malone is a Medicare provider. Medicare will pay for medical services if there is a medical eye problem, such as cataracts, glaucoma, or diabetes. Medicare does not pay for a routine eye exam or screenings. We file Medicare unassigned which means we require payment on the day services are rendered any reimbursements will be sent to you directly from Medicare if you've met your deductible. If you've not met your deductible the amount will be applied toward your deductible.

The only private insurances accepted in our office is BCBS PPO, Humana, MetLife, Eyemed, Aetna, and Eyetopia. We do require private insurances be pre-authorized before the day of the visit in order to inform you of any out of pocket fees since payment is required the day services are rendered. If you have another type of private insurance coverage for eye care, we will be happy to supply you with an itemized Superbill for you to submit your claim.

____ _____/_____/_______

Patient's Signature Date

If you are signing as personal representative of the patient, please indicate your relationship. If you are signing for a minor, you attest that you have legal authority to make medical decisions for the minor.

____ ________________ _____/_____/______

Representative's Signature Relationship Date