Patient Information Sheet

Dr./Mr./Mrs./Ms.: (Last Name)_____ (First)_____

Name you prefer to be called_____

Address:_____(City)_____(State)_____(Zip)_____

Phone: (Cell) (_____)_____-_____ (Home) (_____) _____-_____

E-Mail Address: _____ Sex: M/F Marital Status: S/M

Today's Date: _____/____/____Date of Birth: ____/____/_____ Age: _____ Occupation: _____

What is the **PRIMARY** Reason for having your eyes examined today? (Please Circle)

Annual Exam	Desire Contacts	Trouble Seeing Far	Problems with Contacts/Glasses
Red Eye	Having Headaches	Trouble Seeing up close	Other: _____

When Was your Last Eye Exam? _____ Doctor's Name: __ _____

Are you interested in **Contact Lenses**? YES NO
Are you interested in **Lasik Corrective Surgery?** YES NO
Are you interested in Bifocal **Contact Lenses**? YES NO

How did you hear about our office? Internet/Family/Friend/Flier/Other_____

If you were referred by another patient please list their name here_____

Have you ever been diagnosed with any of the following: **(Please write yes or no, DO NOT leave blank)**

High Blood Pressure _____	Diabetes_____	HIV or AIDS_____	Frequent Headaches_____
High Cholesterol _____	Asthma _____	Heart Problems _____	Cancer _____
Thyroid Problems _____	Stroke _____	Sinus Problems _____	
Other Medical Problem (s) _____		Are you currently pregnant or nursing? _____	

Have you ever had any of these Eye Conditions: **(Please write yes or no, DO NOT leave blank)**

Glaucoma _____	Eye Surgery _____	Dry Eyes _____	Retinal Tear/Hole_____
Cataracts _____	Floating Spots _____	Burning _____	Macular Degeneration _____
Eye Injury _____	Flashing lights _____	Itching _____	Other Eye Problem (s) _____
Lazy Eye _____	Blindness _____	Tearing _____	_____

Are you currently taking any medications: YES NO If Yes Please List: _____

_____

Are you allergic to any medications: YES NO If Yes Please List: _____

Do any of your Blood Relatives have a history of: **(Mother, Father, Siblings, Children only)**

Glaucoma _____	Blindness _____	High Blood Pressure _____
Macular Degeneration _____	Diabetes _____	Other Eye Diseases _____

Payment for the doctor is required at time of service

We accept the following forms of payment: Please indicate below how you intend to pay for your examination.

___ Cash ___ Credit Card

If you are using Insurance, please indicate the insurance company here:

Medical Insurance_____ Vision Insurance _____

Insurance Consent: (Your signature is required below which will allow us to bill your insurance company) I request that payment of authorized insurance benefits either to me or on my behalf be made to **Aaron R Mallie O.D., P.A.** for any services furnished me by that doctor. I authorize any holder of medical information about me to 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 also understand that if my insurance company does not provide payment to **Aaron R Mallie O.D., P.A.** I will be billed for and agree to pay for said services

Patient Signature: _____Date:_____

Authorization for release of Information

Please check each person/entity that you approve to receive information

☐ Voice Mail

☐ Email _____
(provide email address)

☐ Text Message

I understand that if email and text are not sent in encrypted manner, there is a risk they could be accessed inappropriately. I still elect to receive email communication.

☐ Parent or Spouse _____
(provide name and phone number)

☐ Doctor: _____
(provide name and phone number)

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____ _____

Signature or Patient or Guardian Date