



## Welcome to our office!

To provide you with the best care possible, please answer the questions below.

### Patient Information

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_  
 Dr.                       Mr.                       Mrs.                       Ms.                       Miss

Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

- Single                       Married                       Partnered                       Widowed  
 Separated                       Divorced                       Minor

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M / F Occupation: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

If you are a student, name of school/college: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies/Sports: \_\_\_\_\_

Spouse or Parent's Name (if minor): \_\_\_\_\_

Children's Names/Ages: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_

Name	Cross Streets	Phone Number
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### Insurance Information

Vision Insurance Company \_\_\_\_\_ Medical Insurance Company \_\_\_\_\_

Medical Insurance ID# \_\_\_\_\_ Primary Policy Holder Name \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_

I authorize the doctor to bill my insurance carrier on my behalf. I request that payment of authorized insurance benefits be made to the doctor for any services furnished for me by this office. I understand that I am financially responsible for any balance not covered by my insurance carrier, and that a quotation of benefits is not a guarantee of coverage.

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Patient Eye & Medical History



Date of last eye exam: \_\_\_\_\_

Where? \_\_\_\_\_

Do you wear glasses? Y / N      How old are your glasses? \_\_\_\_\_      Interested in contact lenses? Y / N

Do you wear contact lenses? Y / N      If yes, type/brand: \_\_\_\_\_      Do you sleep in your contacts? Y / N

### Check if you have/had any of the following:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Eye Injury          | <input type="checkbox"/> Retinal Detachment   | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> Cataracts                |
| <input type="checkbox"/> Lazy Eye/Strabismus | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Eye Surgery: _____ | <input type="checkbox"/> Other Eye Disease: _____ |

### Check all that apply:

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> Blurred Vision Distance | <input type="checkbox"/> Blurred Vision Near | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Red Eyes          | <input type="checkbox"/> Unusual Discharge   |
| <input type="checkbox"/> Stinging/Burning        | <input type="checkbox"/> Flashes             | <input type="checkbox"/> Floaters      | <input type="checkbox"/> Eyestrain/Fatigue | <input type="checkbox"/> Headaches/Migraines |

Other Visual Symptoms:

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### Have you ever been diagnosed with:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Diabetes ( Type 1 / Type 2 ) | <input type="checkbox"/> Sjogren's            | <input type="checkbox"/> High Blood Pressure            |
| <input type="checkbox"/> High Cholesterol             | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Thyroid Disease ( Low / High ) |

Other Health Problems:

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Do you have visual difficulty when driving?      Y / N      If yes, explain: \_\_\_\_\_

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

Do you drink alcohol?      Y / N      If yes, type/amount/how often: \_\_\_\_\_



**Review of Symptoms**

Have you had any ongoing problems with any of the following systems?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
Weight Loss/Gain	<input type="radio"/>	<input type="radio"/>	Allergies/Hay Fever	<input type="radio"/>	<input type="radio"/>
Skin Conditions	<input type="radio"/>	<input type="radio"/>	Sinus	<input type="radio"/>	<input type="radio"/>
Headaches	<input type="radio"/>	<input type="radio"/>	Chronic Cough	<input type="radio"/>	<input type="radio"/>
Migraines	<input type="radio"/>	<input type="radio"/>	Dry Throat Mouth	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>
Kidney	<input type="radio"/>	<input type="radio"/>	Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>
Stomach/Intestines	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>

If “yes” to any of the above or if a condition is not listed, please explain below:

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**Family Eye & Medical History**

Please check any conditions that have occurred in your immediate family:

<u>Disease/Condition</u>	<u>Yes</u>	<u>No</u>	<u>Relation</u>	<u>Disease/Condition</u>	<u>Yes</u>	<u>No</u>	<u>Relation</u>
Blindness	<input type="radio"/>	<input type="radio"/>	_____	Diabetes	<input type="radio"/>	<input type="radio"/>	_____
Cataract	<input type="radio"/>	<input type="radio"/>	_____	Heart Disease	<input type="radio"/>	<input type="radio"/>	_____
Glaucoma	<input type="radio"/>	<input type="radio"/>	_____	Cancer	<input type="radio"/>	<input type="radio"/>	_____
Macular Degeneration	<input type="radio"/>	<input type="radio"/>	_____	Thyroid	<input type="radio"/>	<input type="radio"/>	_____



**Use and Disclosure of Public Information**

To whom may we release OR discuss information regarding your healthcare, billing, and protected health information? (This includes eyeglasses and contact lenses)

Your information will not be released to anyone without your written consent. You may change who you share this information with at any time by updating this form.

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

Patient Name (Printed): \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (Signature): \_\_\_\_\_ Date: \_\_\_\_\_



### **Retinal Imaging**

Here at Mallinger Family Eye Care we take great pride in providing extremely thorough, comprehensive ocular examinations. To allow our doctors to confidently evaluate the health of the entire eye, our office utilizes an Optomap Widefield Retinal Camera and Optical Coherence Tomography (OCT). This allows our doctors to view, evaluate, and document the health of the back of your eyes and to detect and treat potential sight-threatening ocular diseases as early as possible.

**We discount this price for you to \$39.**

If you have any questions, please ask our staff.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_





## **WOW Eyewear Guarantee**

Mallinger Family Eye Care is committed to selling only the highest quality, premium products. We offer a 12-month manufacturer's warranty for all our frames and lenses. Providing you with the best quality eyewear and your complete satisfaction are extremely important to us. We provide a guarantee for our products with a co-payment of \$25 per claim.

## **Prescription Glasses**

Prescription glasses are custom ordered and created for each individual patient therefore are not eligible for a refund. Your satisfaction is of utmost importance so we will work with you to provide you with the clearest, most comfortable vision possible with your custom eyewear. Our skilled opticians are always happy to adjust your glasses and consult with you for all your eyewear needs.

## **Contact Lenses**

For those who purchase contact lenses we will gladly replace any torn lenses. If your prescription changes before your contact lens supply is exhausted, we will gladly exchange any unopened boxes.

## **Return Policy for Eyeglasses & Contact Lenses**

If there are any discrepancies between the Doctor's prescription and the lenses manufactured by our lab, we will re-make your lenses at no additional cost within 60 days of the original purchase date. Any changes to the original lens order will be the responsibility of the patient and must be made within 60 days of the original purchase date.

*Professional services are non-refundable. \*Adjustments and minor repairs are provided free of charge*

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_