

**Timothy J. Malone, M.D.**  
**Patient Registration Form**

**PERSONAL INFORMATION (Please Print)**

Dr.    Mr.    Mrs.    Ms.    Miss   Marital Status: \_\_\_\_\_ Date: \_\_\_\_\_

**First Name:** \_\_\_\_\_ **M.I.:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_    M    F   **SSN:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
(Street) (City, State, Zip Code)

**Home Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Financially Responsible Person:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

Financially Responsible Person's Address: (if different than patient)

\_\_\_\_\_ **Phone:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Referring Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Insurance:**

**Carrier:** \_\_\_\_\_ **ID:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Secondary Insurance:**

**Carrier:** \_\_\_\_\_ **ID:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Tertiary Insurance:**

**Carrier:** \_\_\_\_\_ **ID:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policy Holder:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

HIPAA Notice of Privacy Practices is located underneath this form. Please review the notice and advise staff if you would like to obtain a copy.

## FINANCIAL POLICY STATEMENT

Welcome to the office of Timothy J. Malone, M.D. We are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. We ask that you **carefully read and sign** the following policy. We must emphasize that, as your medical care provider, our relationship is with you and **not** your insurance carrier. As a courtesy to you, we will file your claim with your insurance company. However, **you are the sole responsible party for all charges incurred and guarantee payment** thereof. If we are contracted with your insurance company, including Medicare, we will accept assignment. You will be responsible for your payment portion at the time of service. Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party. You are expected to understand your benefits coverage and responsibility. This includes obtaining any referrals and/or authorizations, which your insurance company requires **before** care is provided. All co-pays, co-insurance and deductibles are due and payable at the time service is rendered. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payments at the time services are rendered. Please be advised that we do not participate with most vision care programs.

In consideration of the services provided by Timothy J. Malone, M.D., you agree to abide by the terms of this Financial Statement.

**Patient or Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PATIENT'S AUTHORIZATION

I authorize Timothy J. Malone, M.D., PC to apply for benefits on my behalf for service rendered. I request payment from Medicare, MediGap, and/or insurance benefits be made directly to Timothy J. Malone, M.D., PC.

I certify that the information I have provided on every page of this form is correct. I authorize the release of any necessary information, including medical information for this and any related claim to the above named carrier(s), or in the case of Medicare Part B benefits, to the Social Security Administration and Center for Medicare Services. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing.

**Patient or Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## REFRACTION SERVICE AND FEE

A refraction is the measurement with lenses of your eyes' best ability to see. Without the refraction, you can not be prescribed glasses or contact lenses. In some cases, refraction is a necessary diagnostic tool to determine the visual capability of the eyes due to medical eye conditions or eye injuries. The refraction is a special ophthalmic service, like the visual field exam, and is separate from the eye exam. The refraction is covered by some insurance plans, but not others, including Medicare. The refraction fee is \$40.00. You must notify Dr. Malone at the time of your visit if you do not want this service.

Patient Acknowledgment: I have read the above information and understand that the refraction may be considered a non-covered service by my insurance company. I accept full financial responsibility for the cost of this service. I understand that any co-payment, coinsurance, or deductible I may have is separate from and not included in the refraction fee.

**Patient or Responsible Party Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MEDICAL HISTORY QUESTIONNAIRE**

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I. \_\_\_\_\_

**Please answer the following questions about your current eye problems and medical history:**

1. What problems are you CURRENTLY having with your eyes? Which eye? When did the trouble begin?

\_\_\_\_\_

2. Have you had any eye problems in the past (e.g., cataract, glaucoma, retina problems, eye surgery, etc..)?

Yes  No If yes, please explain:

\_\_\_\_\_

3. Have you ever been treated for any medical conditions (e.g., diabetes, high blood pressure, heart disease, asthma, etc..)?

Yes  No If yes, please explain:

\_\_\_\_\_

4. Current medications (including eye drops): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Do you have any allergies to medications? \_\_\_\_\_

6. Have you had any of the following problems? Yes No If yes, please explain:

Chronic fever, unexpected weight loss/gain, fatigue?  Yes  No \_\_\_\_\_

Ear/nose/throat problems (e.g. hearing loss, sinus problems)?  Yes  No \_\_\_\_\_

Heart problems (e.g. chest pain, irregular heartbeat)?  Yes  No \_\_\_\_\_

Respiratory problems (e.g. shortness of breath, wheezing, asthma, bronchitis)?  Yes  No \_\_\_\_\_

Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)?  Yes  No \_\_\_\_\_

Urinary problems (e.g. pain or discomfort, bladder infections)?  Yes  No \_\_\_\_\_

Skin disease (e.g. rashes, eczema, dermatitis)?  Yes  No \_\_\_\_\_

Musculoskeletal problems (e.g. muscle aches, arthritis, swollen joints)?  Yes  No \_\_\_\_\_

Neurologic problems (e.g. numbness, weakness, paralysis, headaches)?  Yes  No \_\_\_\_\_

Hematologic/Lymphatic problems (e.g. blood disorders, leukemia)?  Yes  No \_\_\_\_\_

Allergic/Immunologic problems (e.g. hay fever, allergies)?  Yes  No \_\_\_\_\_

Endocrine problems (e.g. thyroid problems)?  Yes  No \_\_\_\_\_

Psychiatric problems (e.g. depression, anxiety)?  Yes  No \_\_\_\_\_

7. Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)?

Yes  No If yes, please explain: \_\_\_\_\_

8. Do you smoke? \_\_\_\_\_ If yes, how much? \_\_\_\_\_ Drink alcohol? \_\_\_\_\_ If yes, how much? \_\_\_\_\_

Reviewed by physician Comments: \_\_\_\_\_