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

PERSONAL INFORMATION (Please Print)

❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss Marital Status:_____ Today's Date: _____

First Name: _____ **M.I.**_____ **Last Name:**_____

Date of Birth:_____ Age:_____ ❑ M ❑ F SSN:_____

Address:_____
(Street) (City, State, Zip Code)

Home/Main Phone:_____ Cell/Other Phone:_____

Work Phone:_____ Email Address:_____

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

❑Yes ❑No (Please check one) Is your policy is an Affordable Healthcare Act/Tiered Pathway insurance policy? (**Please Note:** Dr. Malone does not yet participate with some of these types of insurance plans and you will be responsible for any uncovered charges by this policy).

Dr. Malone does not participate with vision plans. Please verify your coverage.

Primary Insurance:

Carrier:_____ ID:_____ Group #: _____

Policy Holder:_____ Relationship:_____ **DOB:** _____

Secondary Insurance: **Insurance Policy Holder's SSN:**_____

Carrier:_____ ID:_____ Group #: _____

Policy Holder:_____ Relationship:_____ **DOB:** _____

Tertiary Insurance:

Carrier:_____ ID:_____ Group #: _____

Policy Holder:_____ Relationship:_____ **DOB:** _____

HIPPAA 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 have read and 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 $50.00. 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. 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?	❑	❑	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems)?	❑	❑	_____
Heart problems (e.g. chest pain, irregular heartbeat)?	❑	❑	_____
Respiratory problems (e.g. shortness of breath, wheezing, asthma, bronchitis)?	❑	❑	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea)?	❑	❑	_____
Urinary problems (e.g. pain or discomfort, bladder infections)?	❑	❑	_____
Skin disease (e.g. rashes, eczema, dermatitis)?	❑	❑	_____
Musculoskeletal problems (e.g. muscle aches, arthritis, swollen joints)?	❑	❑	_____
Neurologic problems (e.g. numbness, weakness, paralysis, headaches)?	❑	❑	_____
Hematologic/Lymphatic problems (e.g. blood disorders, leukemia)?	❑	❑	_____
Allergic/Immunologic problems (e.g. hay fever, allergies)?	❑	❑	_____
Endocrine problems (e.g. thyroid problems)?	❑	❑	_____
Psychiatric problems (e.g. depression, anxiety)?	❑	❑	_____

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.
9. Do you smoke?_____ If yes, how much?_____ Drink alcohol?_____ If yes, how much?_____

Reviewed by physician Comments:_____