Mallinger FAMILY EYE CARE

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

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:

- ☐ Eye Injury
- ☐ Retinal Detachment
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Lazy Eye/Strabismus
- ☐ Macular Degeneration
- ☐ Eye Surgery: _____
- ☐ Other Eye Disease: _____

Check all that apply:

- ☐ Blurred Vision Distance
- ☐ Blurred Vision Near
- ☐ Double Vision
- ☐ Red Eyes
- ☐ Unusual Discharge
- ☐ Stinging/Burning
- ☐ Flashes
- ☐ Floaters
- ☐ Eyestrain/Fatigue
- ☐ Headaches/Migraines

Other Visual Symptoms:

_____

Have you ever been diagnosed with:

- ☐ Diabetes (Type 1 / Type 2)
- ☐ Sjogren's
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Rheumatoid Arthritis
- ☐ Thyroid Disease (Low / High)

Other Health Problems:

_____

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?

	Yes	No		Yes	No
Weight Loss/Gain	O	O	Allergies/Hay Fever	O	O
Skin Conditions	O	O	Sinus	O	O
Headaches	O	O	Chronic Cough	O	O
Migraines	O	O	Dry Throat Mouth	O	O
Seizures	O	O	Asthma	O	O
Kidney	O	O	Chronic Bronchitis	O	O
Stomach/Intestines	O	O	Emphysema	O	O

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

_____

_____

Family Eye & Medical History

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

Disease/Condition	Yes	No	Relation	Disease/Condition	Yes	No	Relation
Blindness	O	O	_____	Diabetes	O	O	_____
Cataract	O	O	_____	Heart Disease	O	O	_____
Glaucoma	O	O	_____	Cancer	O	O	_____
Macular Degeneration	O	O	_____	Thyroid	O	O	_____

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: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Name (Printed): _____ Date: _____

Patient Name (Signature): _____ Date: _____

Mallinger
FAMILY
EYE CARE

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 utilitizes 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. In most cases, pupillary dilation with eyedrops is not necessary, but this will be determined by the doctor on an individual basis.

Most insurance companies discount this price for you to $39.

If you have any questions, please ask our staff.

Patient/Guardian Signature: _____Date: _____

optomap®
ultra-widefield retinal imaging

Practice & Office Policies

Our Notice of Privacy Practices and Office Policies are available at the reception desk. The Privacy Practice Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information.

You are entitled to a copy of this Notice as well as our Office Policy Notice and copies are available at your request. I have reviewed a copy of the HIPAA Notice of Privacy Practices and office policies.

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: _____