ALAN R. MALOUF, MD, PA

17000 Science Drive, Suite 108
Bowie, Maryland 20715

PATIENT REGISTRATION

PLEASE PRINT

First Name________	MI________	Last Name________
Address________		
City________	State________	Zip Code________
Home #________	Work #________	Cell #________
Male / Female ________	Date of Birth________	Marital Status________
Employer________		
Patient Email (Optional)________		
Emergency Contact________	Contact's Home #________	

Name of Person Financially Responsible________		
Address________		
City________	State________	Zip Code________
Home #________	Work #________	Cell #________
Relationship to Patient (Child, Spouse, Self)________		

Referring Physician________
Primary Care Physician________

Name & Location of Local Pharmacy ________
Name of Prescription Mail-In Service ________

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PRIMARY INSURANCE: Insurance Company Name___________		
ID or Policy #___________	Group #___________	
Insurance Company Address___________		
City___________	State___________	Zip Code___________
Policy Holders Name___________		
Address (if different from above) ___________		
Date of Birth___________	Relationship to Patient___________	

SECONDARY INSURANCE: Insurance Company Name___________		
ID or Policy #___________	Group #___________	
Insurance Company Address___________		
City___________	State___________	Zip Code___________
Policy Holders Name___________		
Address (if different from above) ___________		
Date of Birth___________	Relationship to Patient___________	

TERTIARY INSURANCE: Insurance Company Name___________		
ID or Policy # ___________	Group #___________	
Insurance Company Address ___________		
City___________	State___________	Zip Code___________
Policy Holders Name___________		
Address (if different from above) ___________		
Date of Birth___________	Relationship to Patient___________	

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ACKNOWLEDGEMENTS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. I authorize *Dr. Alan R. Malouf* and/or such assistants as may be designated by him to administer dilating eye drops. I am aware that the eye drops are necessary to diagnose my condition.

I certify that the information I entered is accurate and true to the best of my knowledge and is only to be used for treatment, billing & processing of insurance benefits. I will not hold *Alan R Malouf, MD, PA* responsible for any errors or omissions that I have made in the completion of this form. I further authorize the release of any necessary information, including medical information, to my insurance company in order to determine insurance benefits to which I may be entitled. This authorization may be revoked by me at any time in writing. I authorize *Alan R Malouf, MD, PA* to release and or send medical information regarding my case to other consulting and/or referring physicians.

I understand and agree that regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. All balances that are past 90 days may be sent to a collection agency. Should your account be sent to a collection agency, you will be financially responsible for all collection fees and legal fees that our office incurs to collect the outstanding delinquent balance. Your account will be processed an additional 35% to cover these costs. Patients without healthcare coverage are expected to pay in full at the time of service.

I also understand that I am responsible for obtaining authorization or a referral from my primary care physician for all visits, including follow up appointments and any surgery. I understand that I am responsible for charges incurred for services considered to be non-covered by my insurance company and are payable at the time of service. This may include, but is not limited to, the refraction. An explanation of the refraction is available upon request.

I have read and understand the financial policy of the office and agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the office. ***Effective 10/1/2016.***

PATIENT/GUARDIAN SIGNATURE__________________________________ **DATE**____________

History & Intake Form

Past Medical History: (please circle all that apply)

- Anxiety
- Arthritis (type:___________________)
- Artificial Joints
- Asthma
- Atrial Fibrillation (irregular heartbeat)
- Bone Marrow Transplantation
- BPH
- Cancer (Breast, Colon, Lung, Prostate)
  - Other:________________________
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/AIDS
- High Cholesterol
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lupus
- Lymphoma
- Pacemaker
- Radiation Treatment
- Seizures
- Stroke
- Valve Replacement
- None
- Other________________________
- ____________________________

Past Surgical History: (please circle all that apply)

- Appendix Removed
- Bladder Removed
- Mastectomy (Right, Left, Bilateral)
- Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy (Right, Left, Bilateral)
- Colectomy: Colon Cancer Resection
- Colectomy: Diverticulitis
- Colectomy: IBD
- Gallbladder Removed
- Coronary Artery Bypass
- Coronary Angioplasty (PTCA)
- Mechanical Valve Replacement
- Biological Valve Replacement
- Heart Transplant
- Joint Replacement-Knee (Right, Left, Bilateral)
- Joint Replacement-Hip (Right, Left, Bilateral)
- Joint Replacement within last 2 years
- Kidney Biopsy
- Kidney Stone Removal
- Kidney Transplant
- Ovaries Removed: Endometriosis
- Ovaries Removed: Cyst
- Ovaries Removed: Ovarian Cancer
- Prostate Removed: Prostate Cancer
- Prostate Biopsy
- TURP
- Skin Biopsy
- Basal Cell Cancer Surgery
- Squamous Cell Carcinoma Surgery
- Melanoma Surgery
- Spleen Removed
- Testicles Removed (Left, Right, Bilateral)
- Tonsillectomy
- Hysterectomy: Fibroids
- Hysterectomy: Uterine Cancer
- Hysterectomy: Cervical Cancer
- Hysterectomy: Endometriosis
- None
- Other____

Ocular History: (please circle all that apply)

- Allergic Conjunctivitis
- Blepharitis
- Cataract (Left Eye, Right Eye)
- Corneal Dystrophy (Left Eye, Right Eye)
- Diabetic Retinopathy (Left Eye, Right Eye)
- Dry Eyes
- Glaucoma (Left Eye, Right Eye)
- Keratoconus (Left Eye, Right Eye)
- Macular Degeneration (Left Eye, Right Eye)
- Macular Pucker (Left Eye, Right Eye)
- Narrow Angles (Left Eye, Right Eye)
- Ocular Hypertension (Left Eye, Right Eye)
- Ophthalmic Migraine
- Pseudoexfoliation
- Retinal Tear (Left Eye, Right Eye)
- Strabismus
- PVD (vitreous detachment) (Left Eye, Right Eye)
- Vitreous Floaters (Left Eye, Right Eye)
- None
- Other_____________________________________

Do you wear Contact Lenses? Yes/No If yes, please list brand name:____________________

Ocular Surgery: (please circle all that apply)

Blepharoplasty (Left Eye, Right Eye)
Cataract Surgery (Left Eye, Right Eye)
Corneal Transplant (Left Eye, Right Eye)
DSAEK (Left Eye, Right Eye)
Eye Muscle Surgery
Intravitreal Injections (Left Eye, Right Eye)
Laser for Glaucoma (Left Eye, Right Eye)
Laser for Diabetes (Left Eye, Right Eye)
LASIK (Left Eye, Right Eye)
PRK (Left Eye, Right Eye)
Ptosis Repair (Left Eye, Right Eye)
Punctal Plugs (Left Eye, Right Eye)
Strabismus Surgery
Retinal Laser (Left Eye, Right Eye)
Trabeculectomy (Left Eye, Right Eye)
Tube Shunt (Left Eye, Right Eye)
Vitrectomy (Left Eye, Right Eye)
YAG Capsulotomy (Left Eye, Right Eye)
None
Other____________________

Medications: (please list all current medications)

____
____
____
____
____

None

Allergies: (please list all allergies)

____
____
____

None

Social History: (please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Family History: (please circle all that apply)

Blindness
Cancer
Cataracts
CVA (stroke)
Diabetes
Glaucoma
Heart Disease
Macular Degeneration
Migraine
Retinal Detachment
Strabismus
None

Other____________________

FOR FEMALES: Is there a chance you might be pregnant? Yes/No

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FINANCIAL POLICY & NON-MEDICAL FEES

We are happy to accommodate our patients' needs for various administrative services that are not covered by insurance. These may include, but are not limited to, the following:

REQUEST FOR MEDICAL RECORDS

Maryland law allows physicians to charge patients (or the patient's "personal representative") a fee for copying medical records. The charges may be adjusted annually according to changes in the law. Effective immediately, the fee remains as stated below:

- A fee for copying not to exceed **.76 cents for each page** of the medical record, and
- The actual cost of **postage and handling**.
- A **Preparation Fee of $22.88** may apply.

Your signed authorization is required for each release to yourself or others. The office will provide a Records Release form. However, you may also use any form or letter which contains the same information requested in our form.

Your *non-urgent request* for copies of your medical records will be processed in 3-5 business days. Fees for processing your requests will be billed to your account and are due immediately prior to the release of records.

Your *urgent request* for records sent to another provider will be faxed as soon as possible at no charge for 5 or fewer pages.

We will work with you to minimize your cost for records. There is ***no charge*** for letters sent back to your primary care physician or sent to a referring physician. This is part of our coordination of your care.

OTHER FEES NOT COVERED BY INSURANCE

Single/Multi Page Forms............................... $25.00 These forms will be completed within 1 week

Returned Check Fee....................................... $35.00 Payable immediately + original amount due

Refraction Fee.. $40.00 Some medical insurance plans will cover this. If your plan does not cover the refraction, the fee is due at the time of service. Medicare does NOT cover the refraction. We will provide a detailed receipt with necessary information which you may choose to submit to your *vision plan* since we do not participate with these plans.

MVA Forms.. No Charge. (At this time the office is not charging a fee.) You may bring your MVA form to your scheduled appointment, and it will be completed at that time. If you bring/mail your MVA form to us, the doctor will usually complete it the same day. However, it could take 3-5 days to complete. You may pick up your form or have it mailed to your home. We cannot mail your form directly to the MVA.