Malik Eye Care

MEDICINE AND SURGERY OF THE EYE

NEW PATIENT INTAKE FORM

Today's Date: ___/___/_____

FIRST NAME:	**LAST NAME:**	**MIDDLE INTIAL:**
DATE OF BIRTH: / /	**SEX: MALE ○ FEMALE ○**	**SSN:**
STREET ADDRESS:		
FLOOR/APT #:	**CITY: STATE:**	**ZIP CODE:**
HOME PHONE: ( ) -	**CELL: ( ) -**	**EMPLOYED? YES NO**
EMAIL:		
EMERGENCY CONTACT PERSON		
NAME:	**PHONE: ( ) -**	**RELATION:**

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____ PCP #: _____

MEDICAL INSURANCE NAME: _____ POLICY #: _____

VISION INSURANCE NAME: _____ POLICY #: _____

PERSONAL MEDICAL REVIEW (CHECK ALL THAT APPLY TO YOU)		
○ DIABETES TYPE 2	○ HIGH BLOOD PRESSURE	○ LUNG DISEASE
○ DIABETES TYPE 1	○ LOW BLOOD PRESSURE	○ KIDNEY DISEASE
○ PREDIABETES	○ HIGH CHOLESTROL	○ CANCER
○ CATARACT(S)	○ LOW CHOLESTROL	○ ASTHMA
○ GLAUCOMA	○ HEART DISORDER	○ ARTHRITIS
○ MACULAR DEGENERATION	○ HEART DISEASE	○ PROSTATE DISEASE

LIST OTHER HEALTH CONDITIONS:

_____

_____

_____

LIST MEDICATIONS:

_____

_____

_____

LIST ALLERGIES: _____

DO YOU DRINK ALCOHOL? _____ **DO YOU SMOKE?** _____ **IF YES, HOW OFTEN?** _____

PHARMACY INFORMATION/ INFORMACION DE LA FARMACIA

NAME/ NOMBRE: _____

PHONE/ NUMERO: _____

ADDRESS/ DIRECION: _____

NOTE: COMPLETE BOTH SIDES OF THIS SHEET

Malik Eye Care

MEDICINE AND SURGERY OF THE EYE

NEW PATIENT INTAKE FORM

Today's Date: ___/___/_____

FAMILY MEDICAL REVIEW (CHECK ALL THAT APPLY TO A RELATIVE)		
○ DIABETES TYPE 2	○ HIGH BLOOD PRESSURE	○ LUNG DISEASE
○ DIABETES TYPE 1	○ LOW BLOOD PRESSURE	○ KIDNEY DISEASE
○ PREDIABETES	○ HIGH CHOLESTROL	○ CANCER
○ CATARACT(S)	○ LOW CHOLESTROL	○ ASTHMA
○ GLAUCOMA	○ HEART DISORDER	○ ARTHRITIS
○ MACULAR DEGENERATION	○ HEART DISEASE	○ PROSTATE DISEASE
○ OTHER (PLEASE LIST):		

HOW DID YOU HEAR ABOUT US? (CHECK ONE)

○ FROM A DOCTOR	○ YELP	○ NEWSPAPER AD	○ WALKED-IN
○ FROM A PATIENT	○ RADIO	○ TELEVISION	○ ZOCDOC
○ GOOGLE	○ HINDI TV	○ FRIEND/ FAMILY	○ OTHER

PATIENT RESPONSIBILITY AGREEMENT/ ACUERDO DE RESPONSABILIDAD DEL PACIENTE

I authorize the release of any information necessary to process medical claims. I request payment of government benefits to myself, or to the party that accepts assignment. I also authorize payment of medical benefits to the physician or supplier for services rendered. I accept responsibility for any balances that my health insurance policy does not cover, including outstanding deductibles and co-payments applied to my account. I also understand that I am responsible for any outstanding balance, plus any legal costs associated with collection proceedings, if my account reaches a collection status for unpaid debts to Malik Eye Care. I also understand that the staff and doctors at Malik Eye Care have requested me to provide any of my previous Doctors, Ophthalmologists, and/or Optometrists records to Malik Eye Care.

*** Por medio de la presente yo autorizo la liberación de mi historial médico o cualquier información necesaria con el propósito de procesar las cuentas de mis atenciones médicas. También autorizo el pago de los beneficios médicos de mi seguro al médico o centro médico. Confirmo que me hayan prestado atención médica. Estoy consciente de que soy responsable por cualquier cuenta que mi seguro médico no cobra, esto incluye cualquier deducible, copago o servicios que mi cobertura no pague por cualquier razón o motivo a pesar de yo tener seguro médico. Si mi cuenta médica llegara a una agencia de colección estoy consciente que si fallo en pagar mi cuenta por mis servicios médicos, yo seré responsable por el saldo completo más los gastos legales de la agencia. También entiendo que el personal y los médicos de Malik Eye Care me han solicitado que proporcione cualquiera de mis registros anteriores de Médicos, Oftalmólogos u Optometristas a Malik Eye Care.

MEDIA RELEASE AGREEMENT/ ACUERDO PARA EL USO DE LOS MEDIOS

I grant Malik Eye Care permission to use any imaging and testing for educational purposes, including social media. I understand that Malik Eye Care will **NOT** release my personal, identifiable information, nor will Malik Eye Care request consent to do so.

*** Le concedo el permiso a Malik Eye Care de usar cualquier imagen y prueba mía con fines educativos, incluyendo medios sociales. Entiendo que Malik Eye Care **NO** divulgara mi información personal y no va a pedir mi permiso para liberar mi identidad.

SIGN/FIRMA: _____ DATE/FECHA: _____/_____/_____

NOTE: COMPLETE BOTH SIDES OF THIS SHEET