Malouf Eye Center
George S. Malouf, Jr., M.D., F.A.C.S.
Marc A. Malouf, M.D.

Eye Physician and Surgeon

4400 Telfair Blvd, Suite D
Camp Springs, MD 20746
(301)423-5252, Fax (301)423-2414

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		SSN
Patient Email		
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

Malouf Eye Center

George S. Malouf, Jr., M.D., F.A.C.S.
Marc A. Malouf, M.D.

Eye Physician and Surgeon

4400 Telfair Blvd, Suite D
Camp Springs, MD 20746
(301)423-5252, Fax (301)423-2414

INSURANCE INFORMATION

Patient Name: Date of Birth:

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**	

Malouf Eye Center

George S. Malouf, Jr., M.D., F.A.C.S.
Marc A. Malouf, M.D.

Eye Physician and Surgeon

4400 Telfair Blvd, Suite D
Camp Springs, MD 20746
(301)423-5252, Fax (301)423-2414

HEALTH HISTORY

ALL INFORMATION ON THIS FORM IS STRICTLY CONFIDENTIAL

Name____ Today's Date__________________ DOB_________

Do you wear contact lenses? YES / NO

Are you interested in a contact lens fitting? Y / N (Separate fee applies)

Are you allergic to any medications? If yes, please list ____
____

If you take medicines, please list____
____
____

Do you smoke? _______ Number of alcoholic drinks per week _______________

Occupation ____

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

Do you have a history of any of the following:

☐ Asthma	☐ Emphysema	☐ Bronchitis	☐ Pneumonia
☐ High Blood Pressure	☐ Liver Problems	☐ Rheumatic Fever	☐ Bleeding Problems
☐ Ulcers	☐ Heart disease	☐ Kidney Problems	☐ Heart murmur
☐ Hay fever	☐ Hiatal Hernia	☐ Diabetes	☐ Seizures
☐ Cancer	☐ Thyroid Problems	☐ Arthritis	☐ AIDS/HIV
☐ Fainting spells	☐ Glaucoma	☐ Macular degeneration	☐ Other

If diabetic, please fill in and circle which ones apply:

Hemoglobin A1c Level: __________ Type 1 or Type 2 Controlled by: Insulin or Medication or Diet ?

Have you had any eye diseases or surgery? If yes, please explain
____
____

Is there a history of eye disease in the family? If yes, please explain
____

Are you under the care of a physician? List name, city and phone number
____

Reason for visit other than routine check up
____

Family members who are patients here
____

Malouf Eye Center

Eye Physician and Surgeon

George S. Malouf, Jr., M.D., F.A.C.S.
Marc A. Malouf, M.D.

4400 Telfair Blvd, Suite D
Camp Springs, MD 20746
(301)423-5252, Fax (301)423-2414

AGREEMENT FORM

Patient Name: Date of Birth:

Dear Valued Patient:

Thank you for choosing **Malouf Eye Center** as your eye care provider. We appreciate the opportunity to examine and care for your eyes. The following agreement outlines our Billing Policy. If you have questions, please feel free to ask one of our knowledgeable staff members.

Missed Appointments:
A **24-hour notice is required to cancel appointments**. Any appointments missed may be subject to a **$30.00 fee**. This will *not* be covered by insurance.

Payment:
Payment is **due at the time services are rendered**. We accept most forms of payment. ***We do not accept checks.*** We will submit a claim to your insurance with the understanding that whatever the insurance does not pay, will become your responsibility. Please have **ALL INSURANCE CARDS AVAILABLE for every visit**. Any change of insurance, address, phone number or emergency contact should be reported immediately as it is your responsibility to do so.

Insurance:
You are responsible for knowing your insurance benefits *to include*: covered services in your plan, physician participation in the plan, and amounts due. If you are an HMO member, *you are responsible* for obtaining referrals from your PCP. Please ask our staff if you will need a referral. **Patients are responsible for deductible balances, co-insurance and non-covered amounts at the time of service.** Any billed balances are due within 30 days of the statement date.

Remember that insurance authorization/referrals for services do NOT guarantee payment. If your insurance does not pay in full within 60 days, we ask that you contact them as charges will then be transferred to you. Should your account become delinquent and be referred to a collection agency, you will be financially responsible for the costs of collection and/or legal fees.

In the world of health insurance, **Medicare and most other carriers do not cover the *refraction* part of the exam.** This part determines whether our vision can be improved with glasses and is needed to dispense/prescribe glasses. Therefore, we want you to be aware there is a **$40.00 fee** for the refraction testing due **at the time services are rendered**. If you have any questions, please feel free to ask.

I understand and agree to this financial agreement.

Signature____Date______________________________