



Moon Valley Eyecare

Dr. Jesse V. Dominguez

PATIENT INFORMATION

Date: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Birth date: _____ Sex: M / F Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (Home) _____ (Cell) _____

OCULAR HISTORY

Date of last eye exam: _____ Name of Doctor _____

Do you currently wear glasses? () Yes () No If yes, () all the time () occasionally () reading () driving

Do you currently wear contacts? () Yes () No / () Soft () Hard. Brand: _____

Whom may we thank for referring you to this office? _____

Are you currently taking any medications? () Yes () No

If yes, please list **medications**: _____

Please list any current **eye drops**: _____

Please list any medications you are **allergic** to: _____

Are you pregnant or nursing? () Yes () No

Do you smoke? () Yes () No

Do you have or have you had any of the following? (Check all that apply)

- | | | |
|--------------------------|---------------------------|----------------------|
| _____ Eye Surgery | _____ Double vision | _____ Glaucoma |
| _____ Eye Injury | _____ Watery Eyes | _____ Diabetes |
| _____ Eye Infections | _____ Red Eyes | _____ Cataracts |
| _____ Itchy/Burning eyes | _____ Itchy/Burning eyes | _____ Pain in eye(s) |
| _____ Floaters | _____ High Blood Pressure | |
| _____ Frequent Headaches | | |

INSURANCE INFORMATION

Name of Insured: _____ Insured's Date of Birth: _____

Insured's Social Security Number: _____ Policy/ID Number _____

Insured's Employer: _____ Insured's Employer Phone # _____

Insurance Company: _____

INSURANCE AGREEMENT AND RELEASE

I, the undersigned, certify that I or my department have insurance coverage with the above Insurance Company and assign directly to Moon Valley Eyecare all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Please check method of today's payment () cash () check or () debit/credit

RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____



FINANCIAL POLICY

In the event that I/we have failed to pay for services provided by this office, and the account is placed for collection, I/we understand and agree that an additional amount equal to 40% of the balance owed at the time the account is placed for collection, will be added to the current balance owed. I/we agree to pay interest at the rate (10%) ten percent per annum until the amount owed is paid in full. I/we further agree to pay all attorneys fee and court cost, necessary to collect this balance. Non-sufficient checks will be charged an additional \$30.00 bank fee.

DATE: _____ **SIGNATURE:** _____
PRINT PATIENT/RESPONSIBLE NAME: _____

MISSED APPOINTMENT POLICY

Our doctor strives to see patients in a timely manner. We respect your time and ask you to respect our time and other patients' needs by keeping your appointment. Each appointment time slot is important and cannot be recovered if a patient chooses not to keep their appointment. We collect fees to ensure that our doctor can continue to see patients. Please keep in mind that each skipped or missed appointment is not just time lost, but also time when other patients cannot be seen.

Each missed appointment will be flagged and you will receive a notice that you have missed your appointment. In addition, your account will be assessed a **\$30 missed appointment fee**. Please note that the fee will not be billed to your insurance.

I understand that failure to give 24-hour notice of cancellation of an appointment or not showing up for an appointment can result in a charge of \$30. This charge is non-covered by your insurance company and is your responsibility.

DATE: _____ **SIGNATURE:** _____
PRINTED NAME: _____

AUTHORIZATION TO RELEASE RECORDS

On April 14, 2003 a new Federal Law HIPAA, went into effect to protect your personal health information (PHI). If you need to authorize someone else to have access to your records in our office please list them and their relationship to you below. Please note, that under this new law we cannot release information to a spouse or parent if the minor is 18 or older, regardless of who is responsible for the charges.

Name: _____ DOB: _____ Relationship to you: _____
Name: _____ DOB: _____ Relationship to you: _____
Name: _____ DOB: _____ Relationship to you: _____

I hereby authorize Moon Valley Eyecare to release my PHI to the listed individuals above until I submit a written request to withdraw them from having such access.

Responsible Party Signature: _____ **Date:** _____