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)

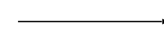
________Eye Surgery ________Double vision ________Glaucoma
________ Eye Injury ________Watery Eyes ________Diabetes
________Eye Infections ________Red Eyes ________Cataracts
________Itchy/Burning eyes ________Heart Disease ________Pain in eye(s)
Floaters/Flashes ________High Blood Pressure
________Frequent 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, final amount based upon EOB. 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 $35.00 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 **$35 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 $35. 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 HIPPAA, 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:______________________