(Please print the answers to all questions. Your information will remain confidential per HIPP

Name: _____ Date: ___/___/___
Last Middle First

Street Address: _____ Apt# _____ City _____ State ____ Zip _____

Home Phone. _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ SS#: _____

Email Address: _____

Sex: ◯ Male ◯ Female Marital Status ◯ Single ◯ Maried ◯ Divorced ◯ Widowed

Occupation (or Grade): _____ Employer (or School): _____

If minor, PARENT/GUARDIAN name: _____

How will you be paying for today's visit? ◯ Cash ◯ Credit/Debit ◯ Vision Plan ◯ Medical Insurance

Who may we thank for telling you about our office? _____

The name of your Medical Doctor is. _____

Personal Eye History

What is the reason for your visit today? _____

Do you have any of the following problems? ◯ Eye Irritation/Infection ◯ Glare ◯ Floaters/flashes
◯ Blurred vision ◯ Eye Itchiness ◯ Headaches ◯ Other _____

When was your last exam? (Approximately) _____ Doctor's Name/Location: _____

Do you wear GLASSES? ◯ Yes ◯ No If YES, do you have them with you TODAY? ◯ Yes ◯ No

When do you wear your GLASSES? ◯ Full Time ◯ Part time ◯ Reading ◯ Distance/Driving ◯ C

Describe your Computer Use: ◯ Extensive (5+ hrs/day) ◯ Moderate (1-4hrs/day) ◯ Low (1hr/day or less) ◯ N

Had any Eye Surgery: ◯ None ◯ Lasik ◯ RK ◯ Cataract ◯ Retina ◯ Glaucoma ◯ Eyelid ◯ O
If you wear Contacts, please answer: Lens type: ◯ Soft Disposable ◯ Soft Yearly ◯ Color ◯ RGP (Hard
◯ Monovision ◯ Bifocal/Multifocal ◯ For Astigm

If you know the Brand and Power of your contacts, please indicate: _____
Do you sleep with your CONTACTS? ◯ Yes ◯ No How often do you replace your lenses with new lenses? _____
How old are the contacts you are currently wearing? _____
Do you have problems with dryness when you wear your contacts? ◯ Yes ◯ No
Any other problems with your contacts? _____

If you have an Eye Infection or an Irritation, please answer these questions:

Which eye? ◯ Both ◯ Right eye ◯ Left eye For how long? _____
What have you done to treat your eye? _____
Did something get into your eye? ◯ Yes ◯ No If yes, what were you doing? _____

Continued on back ----------→

Medical History (Many general medical conditions affect the eye and your vision)

Do you take any prescription or non-prescription medicines regularly? ◯ Yes ◯ No If yes, please list all meds: _____

_____

Do you have any medication allergies: ◯ None known ◯ Penicillin ◯ Sulfa ◯ Other: _____

Below please check all that apply to you or your immediate family. Do you or your family have problems with:

Condition	Patient	Family	Who	Condition	Patient	Family	Who
Weight Problems				Psychiatric Problems			
Cancer				Digestive Issues			
Allergies				Muscle/Bone Problems			
Lupus				Skin Problems			
Heart Disease				Ear/Nose/Throat			
Stroke				Cataracts			
High Blood Pressure				Glaucoma			
High Cholesterol				Macular Degeneration			
Diabetes				Retinal Problems			
Genital Problems				Lazy Eye			
Respiratory Problem				Eye Surgery			
Multiple Sclerosis				Diabetic Retinopathy			
Thyroid Problems				Other Bodily Disease			
Blood problems				Other Eye Disease			

Social History:

Use tobacco? ◯ Yes ◯ No **Alcoholic Beverages?** ◯ Yes ◯ No

Are you pregnant? ◯ Yes ◯ No **Breast Feeding?** ◯ Yes ◯ No

Insurance Information Release:

When making a third party claim, I authorize the release of my medical information to process my third party claim. I authorize Moses Vision Care/Broderick Moses, O.D. to file complaints on my behalf if my third party carrier does not properly handle my claim. I authorize the release of any information pertinent to my case to any third party, adjustor or attorney involved in resolving the financial status of my account. I authorize my third party to pay Moses Vision Care/Broderick Moses, O.D. directly. If my plan does not pay this claim, I agree to be responsible for the payment of these professional services and materials.

Signature_____ **Date**_____

Acknowledgement of Privacy and Voluntary Consent Form

In providing services to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this information in order to treat you and conduct healthcare operations involving our office. The Notice of Privacy Practices posted in our office describes these uses and disclosures in detail. Please refer to this notice any time prior to signing this Consent Form.

I have read this Receipt and Consent Form and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare options.

_____

Signature

If you are signing as a personal representative of the patient, please indicate your relationship to the patient and print your name.

_____ _____

Relationship to Patient **Print Name**

_____ _____/_____/_____

Doctor's Initials **Date**