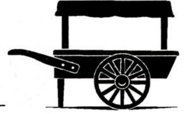
MOSCOT

EYEWEAR AND EYECARE SINCE 1915

WELCOME TO OUR OFFICE



Date ____________________

Last name ____________________ First name ____________________ Middle Initial ____

Social Security # ____________________ Date of birth ____________________

Street ____________________ Apt. # ______ City/State ____________________

Zip Code ____________________ Email Address ____________________

Home Phone ____________________ Cell Phone ____________________

Employer (or School) ____________________ Occupation (or Grade) ____________________

Date of last eye exam and Dr.'s name ____________________

Primary Care Physician's Full Name ____________________ Phone ____________________

Medical/Vision Insurance

Primary Insurance ____________________ Secondary Insurance ____________________

Patient's ID # ____________________ Patient's ID # ____________________

Primary Insured's d.o.b.: ____________________ Primary Insured's d.o.b.: ____________________

Name ____________ SS# ____________ Name ____________ SS# ____________

IF NOT PATIENT: d.o.b.: ____________________ **IF NOT PATIENT:** d.o.b.: ____________________

Name ____________ SS# ____________ Name ____________ SS# ____________

Does your insurance cover routine eye exams? Yes ❑ No ❑ Do you participate in a flexible spending account? Yes ❑ No ❑

Do you need a referral from your primary care physician for medical visits? Yes ❑ No ❑

Medical History

Do you now or have you ever had problems related to:

		No	Yes
Cardiovascular:	Heart	❑	❑
	Hypertension	❑	❑
Constitutional:	Fever	❑	❑
	Weight Loss	❑	❑
Ear, Nose, Throat		❑	❑
Endocrine:	Thyroid	❑	❑
	Diabetes	❑	❑
Gastrointestinal		❑	❑
Genital, Kidney, Bladder		❑	❑
Muscles, Bones, Joints		❑	❑
Females:	Pregnant or Nursing?	❑	❑
Respiratory:	Asthma	❑	❑
	Sinus Condition	❑	❑
Allergic/Immunologic:	Allergies (list) ____________	❑	❑
Neurologic:	Frequent Headaches	❑	❑
Eye:	Eye Injury	❑	❑
	Eye Disease (list) ____________	❑	❑
	Eye Surgery	❑	❑
	Vision Therapy	❑	❑
	Crossed Eye/Lazy Eye	❑	❑
Psychiatric:	Anxiety, Depression	❑	❑
Skin:	Growths, Rashes	❑	❑
Blood Lymph:	High Cholesterol/Anemia	❑	❑
Adverse Reaction to Eye Drops		❑	❑

Other medical conditions or surgeries and dates:

____

____

____

Family Medical History

Is there anyone in the family with:

	No	Yes	Relationship:
Glaucoma	❑	❑	____________
Cataracts	❑	❑	____________
Blindness	❑	❑	____________
Other Eye Disease	❑	❑	____________
Macular Degeneration	❑	❑	____________
Retinal Detachment	❑	❑	____________
Strabismus (eye turn)	❑	❑	____________
Diabetes	❑	❑	____________
Heart Disease	❑	❑	____________
Cancer	❑	❑	____________
High Blood Pressure	❑	❑	____________

Medications/Ocular Medications

Are you currently taking:	No	Yes
Vitamins	❑	❑
Oral Contraceptives	❑	❑

List all prescription medications:

name	dosage	condition treated

List any medications that you are allergic to:

____

____

If you smoke, use alcohol or controlled substances not prescribed by a physician, describe substance and frequency of use:

____

____

Today:	Date:	Date:
Dr.'s Initial:	Dr.'s Initial:	Dr.'s Initial:

Eye/Vision History

Have you ever worn or are you currently wearing glasses?

Yes ❑ No ❑ Age when first worn: ____________

Have you ever worn or are you currently wearing contact lenses?

Yes ❑ No ❑

What kind? ____________

Solutions used ____________

Are you interested in:
Wearing contact lenses?

Yes ❑ No ❑

Would you be interested in trying bifocal contact lenses?

Yes ❑ No ❑

How many hours per day do you work on a computer?________

How much time do you spend outdoors? __________ hrs/week

Hobbies/Interests (check all that apply)

- ❑ Fitness
- ❑ Crafts
- ❑ Computer
- ❑ Music
- ❑ Outdoor Leisure
- ❑ Sportsman
- ❑ Other:

Check the box if you have problems/concerns with, or see any of the following:

Yes		Yes	
❑	Burning	❑	Tearing/Watery eyes
❑	Sensitivity to light	❑	Blurry distance visions
❑	Fainting or dizziness	❑	Itchiness
❑	Flashes of light	❑	Soreness
❑	Redness	❑	Double vision
❑	Gritty feeling in eyes	❑	Seeing at night
❑	Working up close/reading	❑	Eye strain
❑	Sudden loss of vision	❑	Dryness
❑	Objects or spots floating in vision		
❑	Other:		

How did you first hear about our office?

- ❑ Referred by another doctor—If so, who?
- ❑ Referred by a friend—If so, who?
- ❑ Referred by a relative—If so, who?
- ❑ Health insurance provider directory—If so, which one?
- ❑ Office Sign—Location
- ❑ Other:

Patient Obligations Regarding Payments & Insurance Benefits, and HIPPA Acknowledgement

I understand that professional fees are due at the time services are rendered.

I understand that insurance payments are an arrangement between my insurance carrier and myself. I authorize this office to prepare any insurance forms to assist me in receiving reimbursement from my insurance company. I authorize that payment be made directly to this office and be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me, and that **I am personally responsible for payment, regardless of the actual amount of reimbursement made by my insurance company**. I authorize this office to release any information required to process any insurance claims. My signature below will serve as a "signature on file" for purposes of filing claim forms.

ATTENTION MEDICARE PATIENTS ONLY—Federal Medicare laws require us to collect a fee ($25.00) for the determination and release of your refractive error (eyeglass prescription procedure code #92015). Medicare only covers for the evaluation and management of medical eye conditions. No spectacle prescription will be written without the collection of this fee.

I have been given the opportunity to read a copy of Moscot's *Notice of Privacy Practices.*

Signature: ____________ Date: ____________

(Parent or guardian if patient is a minor)