MOSCOT

EYEWEAR AND EYECARE SINCE 1915

PATIENT INTAKE FORM 1 - PATIENT INFORMATION

PATIENT INFORMATION

Last Name: _____

First Name: _____ MI _____

Address: _____

Apt / Floor / Suite: _____

City: _____ State: _____

ZIP Code: _____

Email: _____

Home Phone: _____

Cell Phone _____

Work Phone: _____

Date of Birth: _____

Occupation: _____

Employer: _____

Reason for today's visit: _____

Date of last eye exam (approximate): _____

Do you wear contact lenses? _____

If yes, what kind? _____

Solutions used: _____

Hours per day working on a computer? _____

How did you hear about our office?

- ❑ Referred by another doctor? If yes, who? _____
- ❑ Referred by friend/relative? If yes, who? _____
- ❑ Our big yellow sign.
- ❑ VSP Directory
- ❑ Other. Please specify: _____

* Please be aware that our doctors routinely perform dilated Eye exams to allow evaluation of the internal health of your eyes. This may cause blurred vision and light sensitivity for 2-3 hours afterward. Please consult with your doctor if you have any additional questions.

❑ Yes, dilate my eyes. ❑ No, I do NOT want my eyes dilated.

INSURANCE INFORMATION

Using VSP? ❑ Yes ❑ No

Primary Member's name: _____

Primary Member's SS#: _____

Primary Member's DOB: _____

Interested in Eyewear? ❑ Yes ❑ No

Interested in Contact Lenses? ❑ Yes ❑ No

Primary Physician Name: _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: (_____) _____-_____

CANCELLATION POLICY

If you need to cancel your appointment, kindly notify us *at least* 24-hours in advance. Failure to do so may result in a $40 cancellation fee.

❑ I understand MOSCOT Eyecare's Policies

_____ _____

Patient Signature Date

I authorize MOSCOT Eyecare to release any information to my insurance company for payment/reimbursement. I am personally responsible for payment of professional services rendered.

_____ _____

Patient's Signature Date

I have read the HIPPA information and understand about my record security.

_____ _____

Patient's Signature Date

PROCEED TO THE FOLLOWING PAGE

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PATIENT INTAKE FORM 2 - MEDICAL HISTORY

Check the following you have experienced or have been treated for in the past:

- ❑ Blurred distance vision/near vision
- ❑ Dry eyes
- ❑ Eye Infections
- ❑ Floaters / spots
- ❑ Flashes of lights
- ❑ Lazy eye
- ❑ Watery eye / excessive tearing
- ❑ Double vision
- ❑ Eyestrain / tired eyes
- ❑ Itchiness
- ❑ Injury – If yes,

  please specify_____
- ❑ Cataracts
- ❑ Glaucoma
- ❑ Headaches
- ❑ Macular Degeneration
- ❑ Iritis / Uveitis
- ❑ Retinal Detachment
- ❑ Eye Surgery – If yes,

  please specify_____

Have you ever been diagnosed or treated for the following?

- ❑ Allergy
- ❑ Heart Disease
- ❑ Arthritis
- ❑ High Cholesterol
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Neurological
- ❑ HIV / Hepatitis
- ❑ Blood Disease
- ❑ Autoimmune
- ❑ Thyroid Disease
- ❑ Other:_____

Please list all Medications you are taking (Prescription and Over the Counter):

_____

_____

_____

_____

Are you pregnant? ❑ Yes ❑ No

Are you nursing? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No

Are you allergic to any medications? ❑ Yes ❑ No

Do have any other allergies? ❑ Yes ❑ No

If yes to either of the above, please list:

_____

_____

_____

_____

FAMILY OCULAR AND MEDICAL HISTORY

	WHO
❑ Blindess	_____
❑ Cataracts	_____
❑ Glaucoma	_____
❑ Macular Degeneration	_____
❑ Retinal Detachment	_____
❑ Diabetes	_____
❑ High Blood Pressure	_____
❑ Heart Disease	_____
❑ High Cholesterol	_____
❑ Cancer	_____