MEMORIAL EYE CLINIC

Patient Welcome/Update

Thank you for choosing our practice for your eyecare needs.

(Please Print)

Date:___/___/___

Name_____DOB_____/_____/_____AGE_____SEX M/F

Mailing Address_____City_____State_____Zip_____

Home Phone(___)_____Cell Phone(___)_____Work Phone (___)_____ext_____

E-mail_____Social Security #_____

Occupation_____Employer_____Self Employed_____Student_____

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

With whom are we allowed to discuss your health information?

Spouse_____ Other_____

Name Name/Relationship

Contact Person's Home Phone (___)_____ Cell or Work Phone (___)_____

If patient is under 18 years of age:

I hereby give consent for Dr. Steven B. Moyer to treat: (child's name)_____

Parent/Legal Guardian Signature_____Date___/_____/_____

(PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED)

Do you have vision insurance? Yes No

1)_____

Vision Insurance Company

Do you have medical health insurance? Yes No

1)_____

Primary Insurance Company

2)_____

Secondary Insurance Company

Insured's Information:

Name_____

DOB___/___/___ SS #_____

Employer_____

Relationship to patient_____

(Please present insurance card(s) to receptionist)

I authorize Memorial Eye Clinic to release any medical information necessary to my insurance company to process this claim. This authorization shall apply to all claims submitted on my behalf or for my dependents. I authorize payment of medical benefits to Memorial Eye Clinic. I understand that I am financially responsible to the provider for charges not covered by this authorization (non-covered services) as well as any deductible and/or coinsurance and that payment for these services is expected on the day the service is rendered.

I understand that the doctors at Memorial Eye Clinic observe the privacy practices established by the **HIPAA Compliance Acknowledgement**. Copies of the Notice of Privacy Practices are available upon request.

Name_____Date___/___/___

Print Signature

PLEASE FILL OUT BACK PAGE

EYE HEALTH ASSESSMENT FORM

Date of last exam_____Name of Doctor/Office_____

I currently wear:

☐ Eyeglasses ☐ Computer Glasses ☐ Bifocal Lenses

☐ Reading glasses ☐ Prescription Sunglasses ☐ Progressive Lenses ("No-line bifocal")

Are you currently wearing contact lenses? ☐ Yes ☐ No if yes, what brand?_____

Have you ever worn contact lenses? ☐ Yes ☐ No if yes, what brand? _____

If not currently wearing contacts, are you interested in contact lenses today? ☐ Yes ☐ No

Have you had laser vision surgery? ☐ Yes ☐ No

Would you like to learn more about laser vision procedures? ☐ Yes ☐ No

Are you sensitive to sunlight or glare? ☐ Yes ☐ No
Does nighttime driving bother you? ☐ Yes ☐ No
Do you work at a computer 3 + hours a day? ☐ Yes ☐ No
Do you feel eye fatigue from close-up work? ☐ Yes ☐ No

Do you work indoors, outdoors, or both? (Circle one)

Activities/Hobbies:_____

Please check any of the following conditions that apply to you or your eyes:

☐ Headaches
☐ Flashes of light
☐ Light sensitive
☐ Gritty feeling
☐ Blurred vision
☐ Double vision
☐ Decreased vision
☐ Fluctuating vision
☐ Poor near vision
☐ Poor distance vision
☐ Loss of vision
☐ Eye Strain
☐ Dry eyes
☐ Watering
☐ Burning
☐ Floaters
☐ Glare
☐ Itching
☐ Eye infection
☐ Iritis
☐ Mucous discharge
☐ Eyelid disease
☐ Herpes
☐ Eye pain

Please list current medications and the condition for which it is being taken:

Current Medication(s):	Condition:	Medication Allergies:

Reviewed	Patient Initials
___/___/___	_____
___/___/___	_____
___/___/___	_____