Gary M Moss OD

Patient Information

Thank you for choosing our office! In order to serve you properly, please complete both sides of this form. Please print clearly. **All** information is kept completely **confidential**. Any release of your information without your written consent is in direct violation of Federal law.

Personal Information:

Today's Date: _____

Name: _____
Last First Middle Int.

Name you prefer to be addressed as: _____
Date of Birth: _____ (Mo/Day/Year) Age: _____
Mailing Address: _____
City/State: _____ Zip: _____
Home Phone Number: _____ Work number: _____ Cell number: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated [ ] Partner
Employment Status: [ ] Full-time [ ] Part-time Student: [ ] Full-time [ ] Part-time [ ] Retired
Employer: _____ Occupation: _____ E-mail: _____

Vision Insurance Information: We are unable to bill two insurances for one service. Secondary insurance is used for additional purchases.

Primary Vision Insurance Company: _____ Member's Name: _____

Member's Identification Number: _____ Member's Date of Birth: _____

Member's Employer: _____ Member's relationship to patient: _____

Primary Health Insurance Company: _____ Member's Name: _____

Member's Identification Number: _____ Member's Date of Birth: _____

Member's Employer: _____ Member's relationship to patient: _____

Are you presently or have you ever worn? [ ] Contact Lens [ ] Glasses [ ] Both
Are you interested in learning more about Lasik (refractive) surgery? [ ] No [ ] Yes
Do you use a computer? [ ] No [ ] Yes How many hours a day? _____

How were you referred to our office? Circle one- Advertisement, Friend or Family member _____ Professional_____
Yellow pages, Walk- in, Website_____, Other_____

Medical History

Review of Systems
Are you currently or have you ever experienced any of the following?
Please circle YES/ NO If yes please explain

Constitution YES NO _____
(Chronic fever, fatigue, sudden weight gain or loss)

Heart YES NO _____
(Chest pain, angina, irregular heartbeat)

Respiratory YES NO _____
(Chronic coughing, wheezing, shortness of breath, asthma)

Ear/Nose/Throat YES NO _____
(Chronic sore throat, sinus problems, earache, hearing loss)

Gastrointestinal YES NO _____
(Chronic abdominal pain, heartburn, bowel problems, vomiting)

Urinary YES NO_____
(Chronic pain with urination, blood in urine, kidney problems) **COMPLETE OTHER SIDE**

Hematological YES NO _____

(Blood disorder, bruising, cuts heal slowly, enlarged glands)

Endocrine YES NO_____
(Thyroid problems, diabetes mellitus, insulin resistance)

Integumentary YES NO _____
(Chronic skin problems, eczema, rashes)

Musculoskeletal YES NO _____
(Chronic joint pain, arthritis, swelling, muscle pain or weakness)

Neurological YES NO _____
(Chronic numbness, headaches, migraines, seizures, paralysis)

Psychiatric YES NO _____
(Depression, anxiety, insomnia, confusion)

Allergic/Immunologic YES NO _____
(Food, drugs, seasonal)

Do you use tobacco? [ ] never [ ]rarely [ ] occasionally [ ] often how much?_____

Do you use alcohol? [ ] never [ ]rarely [ ] occasionally [ ] often how much?_____

Family History: mother, father, brother, sister, children or grandparents- list any significant medical disease (such as hypertension, diabetes, cancer, or heart problems etc) or eye disease (cataracts, glaucoma, blindness, or macular degeneration etc.)

_____

_____

PLEASE READ AND SIGN BELOW

Please read carefully: I understand that my medical records are confidential. I understand that by signing this form I am allowing my medical information to be released upon my insurance company's request, for purposes including, but not limited to, provider review functions, claims payment and quality assessment. I also understand that I may revoke this consent by written request, at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent.

I authorize payment of medical/vision benefits to Dr. Gary M Moss for services rendered. Non-covered expenses are due at the time of service. Dr. Moss will seek verification of vision insurance eligibility prior to services rendered. Eligibility authorization obtained is based on finalized claim data from my vision insurance company and not a guarantee of payment by my insurance. I fully understand that I am responsible for any amount not paid by my vision insurance and that this amount is due within 30 days of notification. If payment is not received within 30 days an interest rate of 1.5% will apply for every 30 days past due. All payments made by check that are returned will have an additional charge of $25. A service fee of $25 will be charged to all cancelled orders or appointment cancellations without 24 hours notice.

Contact Lens Wearers or Patients Interested in Contacts: I understand that the fees associated with the fittings and examination for contact lenses may not be covered by my insurance and I am prepared to pay these additional fees. These additional fees for the fitting and evaluation start at $85 and up depending on the type of contact. I understand that many variables exist in the fitting and wearing of contact lenses and that not every contact lens fitting will be successful. If for any reason I decide not to follow through on the contacts lens fitting and supply, I understand the professional fees (examination and/or fitting fees) are non-refundable.

Patient (or Parent) Signature: _____ Date: _____ Dr._____ _____ Date_____

Responsible Financial Party – Name: _____ Address: _____

Int./date_____ Dr./date_____ Int./date_____ Dr./date_____

In order for someone else to pick up materials ordered you must give us authorization per The Federal Privacy Act.

I hereby authorize _____ to pick up any materials ordered.