Welcome to Moss Optical

Name_____

Address_____

City_____ State_____ Zip_____

Home/Cell Phone_____ Work Phone_____

Email Adress_____ Date of Birth_____

Health/ Vision Insurance_____

(We will be happy to submit a claim to your insurance company; however, we cannot guarantee payment. Your insurance company will make that determination after the claim is received.)

What is the reason for your visit today?

___annual eye health exam ___I want new glasses ___ I need more contacts

___medical issue or concern, please explain_____

_____

Do you have any problems reading small print or seeing your computer screen? _____

What sports, hobbies, and activities do you participate in? _____

_____

Do you have a pair of quality sunglasses? **Yes** **No** Do you have computer glasses? **Yes** **No**

Medical History Please check any conditions that have occurred in your immediate family.

___glaucoma ___ cataracts ___macular degeneration

___diabetes ___ retinal detachment ___high blood pressure

Who referred you to Moss Optical? _____

Notice of Privacy Practices-Acknowledgement:

We keep a record of the health care services we provide to you. You may request a copy of you medical record in writing. We will not disclose your record to others unless you direct us to do so or unless legal authorities authorize or compel is to do so. You may request a copy of your medical record or get more information by contacting our Privacy Officer. Our Notice of Privacy Practices is available at the reception desk. The Notice describes in greater detail how your health information may be used or disclosed, and how you can access your information. I acknowledge the Notice of Privacy Practices has been offered to me and is readily available in accordance with the Health Insurance Portability and Accountability Act.

Signature: _____ **Date:** _____

If you would like to be fitted with contact lenses today, please complete page two.