# MOSCOW FAMILY EYE CARE

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Date: ___________

Patient's Full Name: ______________________________________________________________

Mailing Address: _________________________________________________________________

City, state, Zip: _________________________________________________________________

Home Phone #: ____________ Cell Phone #: _______________ Work #: __________________

Date of Birth: _____________ Family Doctor: _________________________________________

Occupation: ___________________________ Last Eye Exam: _____________________________

If patient is under the age 18, please list parent or guardian: ______________________________

**Insurance Information**

Major Medical insurance: _________________________ ID # _____________________________

Vision Insurance Carrier: __________________________ ID # _____________________________

Policyholder/subscriber Name: ____________________ SS # ______________________________

Date of Birth: _________________ subscriber's relationship to patient: _____________________

**I understand that I am ultimately responsible for knowing my insurance eligibility and benefits. I am also responsible for my bill if my insurance does not pay for any reason.**

**Signed: ___________________________________________________**

Reason for visit:

___Annual Exam ___Difficulty Near ___Difficulty Far ___Headaches ___Contact Lens ___Other

| OCULAR HISTORY: | HEALTH HISTORY: | FAMILY HISTORY: | MEDICATIONS: |
|---|---|---|---|
| __Glaucoma | __Hypertension | __Glaucoma | |
| __Cataracts | __Heart Condition | __Cataracts | |
| __Eye Injury | __Heart Attack | __Lazy Eye | |
| __Dry Eye | __Stroke | __Retinal Condition | |
| __Flashing Lights | __Diabetes | __Migraines | |
| __Floaters | __Thyroid | __Blindness | Are you allergic to any meds? |
| __Lazy Eye | __Cancer | __Other | If yes, what? |
| __Itchy Eye | __Arthritis | | |
| __Other | __Steroid Use | | |
| | __Cholesterol | | |

I authorize use of this form on all my insurance submissions (signature on file). I authorize release to all insurance companies. I understand that I am responsible for my bill. I authorize payment go directly to my doctor. I permit a copy of this authorization to be used in place of the original.
Patient/Guardian signature: _____________________________________________________