Today's Date _____

Patient Information

Last Name _____

First Name _____ MI _____

Street _____

City _____ State _____

Zip Code _____

Home phone _____

Work Phone _____

Patient's SSN _____

Date of Birth _____

Age _____ Sex: M F

Employer (or school) _____

Occupation _____

Spouse(or parent name) _____

Spouse (or parent work) _____

E-mail address _____

What is the major purpose of this visit?

_____

_____

Any problems with your current contact lenses or glasses?

_____

_____

_____

Insurnace Information

Please note that insurance does NOT cover the contact lens evaluation and follow-up.

Vision Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Primary Medical Insurance _____

Subscriber Name _____

Subscriber SSN _____

Subscriber Birth Date _____

Do you participate in a flex spending account?

____YES ____NO

How will you settle your account today?

____Cash ____Check ____Credit Card

Vision Source!

Moss Eye Center

Welcome To Our Office

Our mission statement at
Vision Source! Moss Eye Center
is to provide thorough ,state-of-the-art eye care
in a professional and courteous manner
that improves the quality of life for our patients.

Very Important! New Patients Only:

Who may we thank for referring you to our office _____

If not referred, how did you choose our office?

____Another doctor

____Insurance list

____Saw building/sign

____Web Page: Which web site? _____

____other _____

Lifestyle Questions

Do you .....(check if answer is yes)

___ .. work on a computer? If yes, please complete computer questionnaire.

___ .. think you might benefit from thinner, lighter lenses?.

___ .. have interest in a "test drive" of the latest contact lens designs?

___ .. spend time outdoors? How much? _____ Hrs/week

___ .. have prescription sunwear?

___ .. prefer not to wear your glasses at times?

___ .. have more than 1 pair of current prescription eyewear?

___ .. have children?

___ .. have family members in need of eyecare?

Have you ever experienced, been diagnosed or treated for any of the following?

___ Blurry vision
___ Cataracts
___ Crossed eye/eye turn
___ Eye infections
___ Flash of light
___ Glaucoma
___ Headaches
___ Itchiness
___ Macular Dgeneration
___ Retinal Detachment
___ Tearing
___ Uncomfortable glasses
___ Burning
___ Corneal Abrasions
___ Double vision
___ Eye injury
___ Floaters/Spots
___ Grittiness
___ Iritis/Uveitis
___ Lazy eye
___ Occasional dryness
___ Sunlight sensitivity
___ Trouble seeing at night
___ Other eye disorders

The information in this confidential case history form is critical to the evaluation of your vision and health.

Name of Family Physician_____

Town_____

Date of last physical check-up_____

Current Medications (RX or over the counter)

(List name of medications including eye drops, vitamins and birth control pills)_____

_____

_____

Allergies to medications? _____Yes _____No

If so, what medications?_____

_____

Have you had any surgeries? _____Yes _____No

Do you use cigarettes/tobacco, alcohol, or other substances?

_____Yes _____No

Have you ever been diagnosed or treated for the following health problems?

	Yes	No
Allergies	_____	_____
Arthritis	_____	_____
Blood/Lymph	_____	_____
Bronchitis	_____	_____
Cancer	_____	_____
Cholesterol	_____	_____
Diabetes	_____	_____
Digestive	_____	_____
Ear/Nose/Throat	_____	_____
Endocrine	_____	_____
Eczema/Rashes	_____	_____
Fatigue	_____	_____
Fevers	_____	_____
Genitourinary	_____	_____
High Blood Pressure	_____	_____
Ingumentary (Skin)	_____	_____
Kidney	_____	_____
Muscle/Bone	_____	_____
Neurological	_____	_____
Psychological	_____	_____
Respiratory	_____	_____
Sinus	_____	_____
Throat Infections	_____	_____
Thyroid	_____	_____
Unusual weight loss/gains	_____	_____

Patient Eye History

Date of last eye exam_____

By whom?_____

Have you ever tried contact lenses? _____Yes _____No

What kind?_____

Solutions used_____

Are you satisfied with the vision and comfort of your contact lenses?

_____Yes _____No

Would you prefer clear contact lenses or colored lenses?

_____Clear _____Colored

If you wear bifocals, do the lines or head tilting bother you?

_____Yes _____No

Family Medical/Eye History (check all that apply)

Is there a family medical history of any of the following?

_____No _____Yes (Please check boxes)

		Relationship (Mother's or Father's side)
Blindness	_____	_____
Cataracts	_____	_____
Corneal Problems	_____	_____
Diabetes	_____	_____
Heart Disease	_____	_____
Lazy Eye	_____	_____
Macular Degeneration	_____	_____
retinal Problems	_____	_____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company...not Vision Source! Moss Eye Center.

If your insurance company has not reimbursed our office within 60 (or 90) days, the balance will be billed to you and your insurance company will then pay you directly. (If by mistake your insurance company sends the payment to us, we will of course sign over and forward the check directly to you.)

Signature_____

Vision Source / Moss Eyecare

EyeScreen Photographic Examination

We are pleased to offer our patients an advanced retinal exam called EyeScreen. EyeScreen is a high-resolution digital image of your retina that will help us review and compare your retinal health status over time. We will use the EyeScreen exam to document your retinal image for our charts, screen for eye diseases and improve our ability to view your internal retinal health at a much higher resolution than a slit lamp or ophthalmoscope.

Dr. Moss is concerned about retinal problems such as macular degeneration, retinal holes, detachments and diabetic retinopathy (all of which can lead to partial loss of vision or blindness). Additionally, systemic diseases such as diabetes and high blood pressure can be detected with the EyeScreen examination.

You can expect from this exam:

- An annual eye wellness EyeScreen photograph
- The ability to review the images with you (we will show you your retina)
- To be fast, easy and comfortable
- Usually no dilation drops for the test (we will inform you if they are required)

Since insurance will not pay for the EyeScreen exam– **this is considered an out-of-pocket expense.**

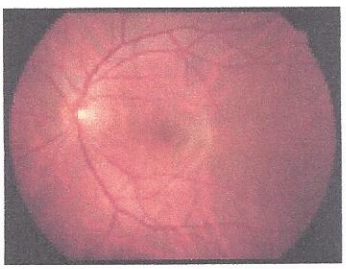
Dr. Moss recommends this procedures for all of his patients and will perform it at a reduced cost when done in conjunction with the basic eye exam. The normal cost for this test is $95.00. When performed on the same day as the eye exam the cost is $49.00. Please check **one** of the following:

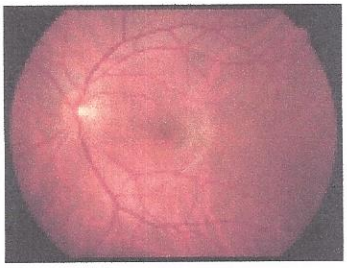
☐ **I AGREE** to have my retinal health evaluated utilizing EyeScreen for an additional cost of $49.00 (a $95.00 value)

☐ **I DO NOT** wish to have my retinal health in this manner. I understand that I will still have a thorough eye examination with slit lamp and ophthalmoscope observation.

_____ _____

Patient Signature Date





Vision Source®
MOSS EYECARE CENTER
EDWIN B. MOSS
Optometric Physician
800 Main St.
Minden, Louisiana 71055
Phone (318) 377-2020

I authorize Dr. Edwin Moss to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such eyecare to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor benefits otherwise payable to me. I understand that my insurance may or may not pay for services rendered. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient (or parent if a minor) Date

DR. EDWIN B MOSS
MOSS EYE CENTER
800 MAIN STREET
PO BOX 626
MINDEN, LA 71055
Ph. 318-377-2020
Fax. 318-377-9833

Member
American Optometric Association

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name _____

Patient number _____

Patient address _____

Patient phone number _____

The Notice of Privacy Practices describes the uses and disclosures of patient health information that may be made without your authorization or consent. This authorization may be used for those specific uses and disclosures of information that require further authorization from you.

I authorize the professional office of my optometrist named above to release health information identifying me [including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released:
   - ☐ All (no restriction)
   - ☐ Describe Information _____

_____

_____

2. To whom the information may be released (name(s) or class(es) of recipients):
   - ☐ All (no restriction)
   - ☐ Recipients (List) _____

_____

_____

3. The purpose(s) for the release (it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
   - ☐ At request of patient
   - ☐ Marketing activities
   - ☐ Other (describe) _____

_____

_____

(over)

4. Expiration date _____ or event relating to the individual or purpose for the release: _____

It is completely your decision whether or not to sign this authorization form. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

If you are authorizing us to use your health information for marketing activities, please be advised that we may receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated _____ Patient Signature _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient: _____

Print Name: _____

Source of Authority: _____