

# MOSCOT

EYEWEAR AND EYECARE SINCE 1915



## PATIENT INTAKE FORM 1 - PATIENT INFORMATION

### PATIENT INFORMATION

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: \_\_\_\_\_  
Apt / Floor / Suite: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_  
ZIP Code: \_\_\_\_\_  
Email: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Reason for today's visit: \_\_\_\_\_

Interested in eyewear?  Yes  No

Interested in contacts?  Yes  No

\*Our doctors routinely perform dilated eye exams to allow evaluation of the internal health of your eyes. Doing so may cause blurred vision and light sensitivity for several hours afterward.

OK to dilate?  Yes  No

Reschedule Dilation?  Yes

OK to do Optos/Optomap Retinal Imaging?  Yes  No

How did you hear about our office?

- Referred by another doctor? If so who? \_\_\_\_\_
- Referred by friend/relative? If so who? \_\_\_\_\_
- Our big yellow sign?
- VSP Directory
- Other? \_\_\_\_\_

### INSURANCE INFORMATION

Using VSP?  Yes  No  
Primary Member's name: \_\_\_\_\_  
Primary Member's SS#: \_\_\_\_\_  
Primary Member's DOB: \_\_\_\_\_  
Would you like to use your VSP benefit toward:  
 Contact Lenses  Eyewear  
Name of Primary Care Physician: \_\_\_\_\_  
Phone of Primary Care Physician: \_\_\_\_\_  
Pharmacy Name: \_\_\_\_\_  
Pharmacy Address: \_\_\_\_\_  
Pharmacy Phone: \_\_\_\_\_  
Pharmacy Plan Member ID: \_\_\_\_\_  
Pharmacy Plan Name: \_\_\_\_\_

I authorize MOSCOT Eyecare to release any information to my insurance company for payment/reimbursement.  
I am personally responsible for payment of professional services rendered.

\_\_\_\_\_  
Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

I have read the HIPPA information and understand about my record security.

\_\_\_\_\_  
Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Today:	Date:
Dr's Initial:	Dr's Initial:

PLEASE PROCEED TO THE FOLLOWING PAGE



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## PATIENT INTAKE FORM 2 - PATIENT HISTORY

### PATIENT EYE HISTORY

Date of last eye exam? \_\_\_\_\_

Do you currently wear contact lenses? \_\_\_\_\_

What kind? \_\_\_\_\_

Solutions used \_\_\_\_\_

How many hours per day do you work on a computer? \_\_\_\_\_

Use a mobile Device? \_\_\_\_\_

### PATIENT MEDICAL HISTORY

**Check the following you have experienced or have been treated for in the past:**

- Blurred distance vision/near vision
- Burning
- Dry eyes
- Eye Infections
- Floaters/spots
- Flashes of lights
- Lazy eye
- Watery eye/excessive tearing
- Double vision
- Itchiness
- Injury - If so, what kind? \_\_\_\_\_
- Cataracts
- Glaucoma
- Headaches
- Macular Degenerations
- Sensitivity to light/glare
- Iritis/Uveitis
- Retinal detachment
- Eyestrain/tired eyes
- Eye surgery
- Loss of vision
- LASIK/PRK
- Color blindness
- History of eye patch

### PATIENT MEDICAL HISTORY

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

- Allergy
- Heart Disease
- Arthritis
- High Cholesterol
- Diabetes
- High Blood Pressure
- Neurological
- Thyroid Disease
- HIV/Hepatitis
- Blood Disease
- Other \_\_\_\_\_

**Please list all Medications you are taking (Prescription and Over the Counter):**

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Are you pregnant?  Yes  No

Do you smoke?  Yes  No

**Allergic to any medications? If yes, what medications?**

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### FAMILY OCULAR AND MEDICAL HISTORY

WHO

- Blindess \_\_\_\_\_
- Cataracts \_\_\_\_\_
- Glaucoma \_\_\_\_\_
- Macular Degeneration \_\_\_\_\_
- Retinal Detachment \_\_\_\_\_
- Diabeters \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Heart Disease \_\_\_\_\_
- High Cholesterol \_\_\_\_\_
- Cancer \_\_\_\_\_

PLEASE PROCEED TO THE FOLLOWING PAGE



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## PATIENT INTAKE FORM 3 - MOSCOT EYECARE INFORMATION

### PAYMENT POLICY

Regrettably, MOSCOT does not accept checks as method of payment.  
Examination copayments are due at time of visit.

### CANCELLATION POLICY

Life happens. We understand. But being stood up bites..

If you need to cancel your appointment, kindly notify MOSCOT Eyecare  
**at least 24-hours** in advance of your scheduled exam. Failure to do so may  
result in a \$40 cancellation fee.

\*If you cancel your appointment within 24-hours of your scheduled exam,  
we will gladly waive the cancellation fee, provided you schedule a new  
appointment within seven days of your original exam.

I have read and agree to the policies listed above.

Patient name (print) \_\_\_\_\_

Patient name (sign) \_\_\_\_\_

Date \_\_\_\_\_

