



Welcome to Our Office

Form 1009-MHQ

Date ___/___/___ (Please Print) [] Appointment [] Walk-in
Name _____ Age ___ DOB ___/___/___ Male Female
Address _____ Home Phone _____
City, State, Zip _____ Work Phone _____
SS# ___-___-___ Email _____ Cell Phone _____
Parent's Name (if patient is minor) _____ Phone _____
Employer _____ Job Description _____

Do you have insurance? Vision [] Yes [] No Major Medical? [] Yes [] No
(You must tell us about your insurance coverage today to use your benefits for today's services)

Insured Name _____ Relation: Self Spouse Parent
DOB ___/___/___ SS# ___-___-___ Email _____
Address ([] Same) _____ Home Phone _____
City, State, Zip _____ Cell Phone _____
Employer _____ Phone _____
Insurance Carrier _____ Phone _____
ID# _____ Group # _____ Other _____

Our Policy on Vision Insurance

There are many different types of vision insurance. We are a participating provider for the most common ones: VSP, Eyemed, Spectera, Anthem, Aetna, and Medicare. For these we follow the provider agreement. We accept other insurances under the following terms: (1) we can obtain a written authorization for eligibility and benefits; (2) you have documentation of coverage; (3) you agree in writing to pay any amounts your insurance denies, and; (4) Moody Eyes will only file for benefits one time. If we cannot obtain authorization then you will be given an itemized statement for you to send for reimbursement. Keep in mind your insurance coverage is a contract between you, your employer, and your carrier. As providers we are not responsible for the terms of your contract. You must tell us about your insurance coverage prior to services in order to receive benefits.

We recommend a dilated retinal exam every year: [] I do not want dilated
The purpose of dilating your pupils is to allow a more thorough examination of your retina and the interior of your eyes. This is extremely important for individuals with diabetes, high myopia, hypertension, glaucoma, systemic disease, over 50 years old, and first time exam.

We take high-definition digital retinal photographs:
We believe every patient should have a permanent photographic retina record. This allows us to go back to this date in time to compare any difference we may observe at a later exam.

We take both vision and medical insurance:
Medical insurance is used for diagnosis and treatment of eye injuries and diseases. Such conditions as glaucoma, red eye, and cataracts may be covered by your medical policy.



Medical History Form

Form 1009-MHQ

Name _____ Age _____ Date ____/____/____

I currently wear: Glasses Contacts Both None

This exam is for: Glasses Contacts Both Other _____

Have you ever been examined at this office? Yes No

When was your last eye exam? 3mos 6mos 1 year Other _____

How did you choose our office? Relative/friend Previous Visit Internet Location
 Insurance List Yellow Pages Ad Other _____

What problems are you having with your eye/vision? Blurred Vision Red Eye(s) Itching
 Trouble Reading Tired Eyes Watering Pain in Eye(s) Double Vision
 Dry Eyes Other _____

List any major surgeries, injuries, and/or hospitalizations you have had: _____

List all medicines you are taking: None List _____

Are you allergic to any medicines? Yes No List _____

Are you pregnant? Yes No Nursing? Yes No

Name of Medical Doctor: _____ Phone _____

Eye History: Do you or anyone in your family have any of these eye health conditions?

- | | |
|--|---|
| <input type="checkbox"/> Glaucoma – you / family | <input type="checkbox"/> Cataracts – you / family |
| <input type="checkbox"/> Macular Degeneration – you / family | <input type="checkbox"/> “Lazy Eye” – you / family |
| <input type="checkbox"/> Retinal Detachment – you / family | <input type="checkbox"/> Eye Infection – you / family |
| <input type="checkbox"/> Dry Eye – you / family | <input type="checkbox"/> Blindness – you / family |
| <input type="checkbox"/> Eye Surgery (explain) _____ | |

Medical History: Have you or any blood relative had any problems in these areas?

- | | |
|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Weight Loss or Gain |
| <input type="checkbox"/> Skin Disorders | <input type="checkbox"/> Headaches, migraines, seizures |
| <input type="checkbox"/> Allergies, chronic cough, dry mouth | <input type="checkbox"/> Asthma, bronchitis, emphysema |
| <input type="checkbox"/> Diabetes, high blood pressure | <input type="checkbox"/> Diarrhea, constipation |
| <input type="checkbox"/> Genitourinary disease | <input type="checkbox"/> Arthritis, muscle or joint pain |
| <input type="checkbox"/> Anemia, bleeding issues | <input type="checkbox"/> Psychiatric treatment |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid or other endocrine disease |
| <input type="checkbox"/> Drink alcohol – socially | <input type="checkbox"/> Use tobacco products |
| <input type="checkbox"/> HIV, hepatitis, syphilis, gonorrhea | <input type="checkbox"/> Other _____ |

Please Explain: _____

We Appreciate You Choosing Moody Eyes

☞ Patient's Signature _____ Date ____/____/____

☞ Doctor's Signature _____ Date ____/____/____