Welcome to

Moorestown Eye Associates

Les Friedman, OD **Kimberly K. Friedman, OD FAAO** **David Kong, OD** **Gregg Abbate, OD** **Tammy Schuler, OD**

TITLE: ***Mr.*** ***Mrs.*** ***Ms.*** ***Miss*** ***Dr.*** ***Other_____***

LAST NAME: _____FIRST NAME_____MI:_____

PARENT/GUARDIAN NAME (*if under 18yo*) _____

ADDRESS : _____

CITY/ST/ZIP_____

SOC SEC #: _____ DATE OF BIRTH: _____

CELL PHONE: ( ) _____ **eMAIL:** _____

HOME PHONE: ( ) _____ WORK PHONE: ( )_____

OCCUPATION: _____

FAMILY DOCTOR: _____ ——> CITY: _____

VISION INSURANCE: _____ ——> Primary Insured Name/DOB/SS#_____

MEDICAL INSURANCE:_____ ——> Primary Insured Name/DOB/SS#_____

Does your MEDICAL insurance require REFERRALS for specialist visits? **YES** **NO**

WHAT PROBLEMS, IF ANY, BROUGHT YOU IN TODAY? _____

LIST ALL MEDICATIONS THAT YOU CURRENTLY TAKE (prescription + over-the-counter):

_____

LIST ANY MEDICATION ALLERGIES: _____

PLEASE CIRCLE ANY ITEMS YOU ARE INTERESTED IN DISCUSSING WITH THE DOCTOR TODAY:

Contact lenses Glasses Sunglasses LASIK Sports Goggles
Swim Goggles Vitamins for Eye Health

PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE OR DO:

Dry eyes	Use rewetting drops more than 2x/day
Red eyes	Often feel like something in eye(s)
Burny eyes	Use Visine-like products
Teary eyes	PRK/LASIK (in past)
Fluctuating vision	Rosacea

We have a high resolution **Digital Retinal Imaging** System that can reduce the frequency that we need to utilize dilating eye drops. Our doctors recommend that all people over 16 years of age have a retinal image taken annually to help monitor eye and overall health. Cost: $20. With certain ocular conditions, your insurance may cover this test. The doctor can discuss this further in the exam room should you have questions.

☐ I accept ☐ I decline

SIGNATURE AUTHORIZATIONS:

HIPAA: Your signature below indicates you have received a copy of the Notices of Privacy Practices of this office

TEXT & EMAIL: Your signature below indicates you consent to email and text communications from our office, including account statements.

INSURANCE: Your signature below authorizes Moorestown Eye Associates to bill your insurance company on your behalf. Moorestown Eye provides BOTH routine eye examination services and medical eye health care and will bill the appropriate insurance carrier(s) for all services received. If medical eye testing is performed on the same day as a routine eye examination, it is possible that BOTH vision *and* medical insurance are billed for the same visit date.

I understand I am responsible for any co-payments, non covered services, and deductibles as required by my insurance plan(s). I agree to the 3 signature authorizations above for HIPAA, TEXT & EMAIL, and INSURANCE.

Signature _____ Date _____