

# PATIENT REGISTRATION

Dr. David C. Moiger License #2055T  
Therapeutic Optometrist

NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST. \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ RESPONSIBLE PARTY IF DIFFERENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_ WK. PHONE \_\_\_\_\_

e-mail: \_\_\_\_\_ MOBILE PHONE: \_\_\_\_\_

HAVE YOU EVER WORN GLASSES? \_\_\_\_\_ CONTACTS? \_\_\_\_\_ SEX:  M  F

DATE OF LAST EXAM? \_\_\_\_\_ RECOMMENDED BY \_\_\_\_\_

DO YOU HAVE VISION INSURANCE? \_\_\_\_\_ COMPANY? \_\_\_\_\_ S.S.# \_\_\_\_\_

## REASON FOR EXAM TODAY? (CHECK AS MANY AS NECESSARY)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ROUTINE CHECK UP | <input type="checkbox"/> EYES WATER    | <input type="checkbox"/> WANT CONTACT LENSES |
| <input type="checkbox"/> LOST GLASSES     | <input type="checkbox"/> EYES BURN     | <input type="checkbox"/> SOFT/DW.,EW.,DISP.  |
| <input type="checkbox"/> BLURRED DISTANCE | <input type="checkbox"/> EYES ITCH     | <input type="checkbox"/> GAS PERMEABLE       |
| <input type="checkbox"/> BLURRED NEAR     | <input type="checkbox"/> EYES FEEL DRY | <input type="checkbox"/> BIFOCAL CONTACTS    |
| <input type="checkbox"/> HEADACHES        | <input type="checkbox"/> PAIN IN EYES  | <input type="checkbox"/> CONTACT PROBLEMS    |
| <input type="checkbox"/> GLARE            | <input type="checkbox"/> SEE "SPOTS"   |  |

## PAST OR PRESENT HEALTH: (CHECK AS MANY AS NECESSARY)

- |  |   |                                      |
|--|---|--------------------------------------|
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> RESPIRATORY PROBLEMS | <input type="checkbox"/> AMBLYOPIA   |
| <input type="checkbox"/> HEART DISEASE       | <input type="checkbox"/> CIRCULATORY PROBLEMS | <input type="checkbox"/> CROSS EYED  |
| <input type="checkbox"/> DIABETES            | <input type="checkbox"/> MULTIPLE SCLEROSIS   | <input type="checkbox"/> RETINAL PRB |
| <input type="checkbox"/> ALLERGIES           | <input type="checkbox"/> GLAUCOMA             | <input type="checkbox"/> EYE INJURY  |
| <input type="checkbox"/> CANCER              | <input type="checkbox"/> ARTHRITIS            | <input type="checkbox"/> EYE SURGERY |
| <input type="checkbox"/> HIV INFECTION       | <input type="checkbox"/> OTHER                |                                      |

IF YOUR FAMILY (BLOOD RELATIVES) HAVE ANY OF THESE, PLEASE LIST.

\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

\_\_\_\_\_  
\_\_\_\_\_

PLEASE LIST ANY MEDICATION ALLERGIES/REACTIONS:

\_\_\_\_\_  
\_\_\_\_\_

**Retinal Imaging** offers a better view and early detection. Digital retinal imaging uses high-resolution imaging systems to take pictures of the inside of your eye. This helps doctors assess the health of your retina and helps them to detect and manage such eye and health conditions as glaucoma, diabetes, and macular degeneration. Finding retinal disorders as early as possible is critical to potentially preventing serious disease progression and even vision loss. Retinal images provide a permanent and historical record of changes in your eye. Images can be compared side-by-side, year after year, to discover even subtle changes and help monitor your health. Retinal images also make it easier for your doctor to educate you about your health and wellness. The two of you can review your images together, and your doctor can point out the various structures of the retina and explain treatment options for any conditions revealed by the pictures. The more you know about eye diseases, the more likely you will understand and follow your doctor's recommendations for treatment and prevention.

**Here in our office we offer Retinal Imaging at \$39** *\*price may vary with benefits*

Dilation is included with Retinal Imaging. Drops are placed in each eye widen the pupil, which is the opening in the center of the iris (the colored part of the eye). Dilating the pupil allows more light to enter the eye the same way opening a door allows light into a dark room. Once dilated, each eye is examined using a special magnifying lens that provides a clear view of important tissues at the back of the eye, including the retina, the macula, and the optic nerve.

*(Please provide your vision insurance information and/or medical insurance to our front desk)*

**Please CIRCLE agree or deny and INITIAL inside the box below**

I **AGREE** to have these tests

I **DENY** to have these tests

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## Some diseases that Retinal Imaging may show

**Age-related Macular Degeneration** Macular degeneration is usually signified by leaking of fluid or bleeding in the back of the eye. This causes central vision loss.

**Cancer** A dark spot at the back of the eye may signal a melanoma, which can grow unnoticed within the retina. If caught early, melanomas can be treated before they cause serious damage and travel to other areas of the body through the bloodstream.

**Diabetic Retinopathy** Diabetes can cause changes in the blood vessels of the retina, like swelling and leakage or the creation of new blood vessels. Blindness can result without early detection.

**Glaucoma** Pressure against the optic nerve and compression of the eye's blood vessels may indicate glaucoma. This disease causes permanent and irreversible vision loss.

**Hypertension (High Blood Pressure)** Signs of high blood pressure often appear first in the eye.

**Indicators** can include narrowing of the blood vessels, spots on the retina, or bleeding in the back of the eye. **Retinal Detachment** Retinas can lift or pull away from the wall of the eye. If not properly treated, this can cause permanent vision loss.

**ACKNOWLEDGEMENT  
OF  
NOTICE OF PRIVACY PRACTICES**

The law requires that David C. Moiger O.D. make every effort to inform you of your rights related to your personal health information. By checking ONE box that applies and my signing below, I acknowledge that:

- I have read or had explained to me David C. Moiger O.D.'s Notice of Privacy Practice and agree to continue my care with David C. Moiger, O.D. under said terms.
- I was given the opportunity to read David C. Moiger, O.D.'s Notice of Privacy Practices and declined but wish to continue my care with David C. Moiger, O.D. under the terms of David C. Moiger, O.D.'s privacy polices.
- I have read or had explained to me David C. Moiger, O.D.'s Notice of Privacy Practice and do not wish to continue my care with David C. Moiger, O.D under said terms.
- The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

\_\_\_\_\_  
\_\_\_\_\_

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

If you are signing as a personal representative of the patient, please indicate your relationship.

\_\_\_\_\_  
Representative

\_\_\_\_\_  
Relationship to Patient