Haddonfield Vision
Dr. Judson Moon Optometrist

Date_____ Last name_____ First name_____

Social Security#_____ Sex M / F Date of birth _____

Street Address_____

City/Town_____State_____ Zip Code_____

Telephone H (_____) _____W (_____) _____

Occupation _____ Any Allergies/Drug Reactions? Yes / No_____

If yes please list_____

How were you referred to us?_____ marital status_____

E-Mail Address_____

Are you getting glasses? Yes / No
Are you getting contacts? Yes / No Are you interested in Laser? Yes / No

Have you ever been treated or have any of the following;

[ ] Heart Disease	[ ] Asthma	[ ] Glaucoma	[ ] Headaches
[ ] Diabetes	[ ] Kidney Disease	[ ] Cataracts	[ ] Contacts
[ ] Type 1	[ ] Eye injury	[ ] Eye Disease	[ ] Eye Glasses
[ ] Type 2	[ ] High Blood Pressure		

Any family history of the above? If yes, list_____

Have you had any eye operations? If yes, explain_____

Have you had any eye injuries? _____

Are you currently taking any medications? Yes / No. If yes please list _____

_____

Any ongoing heath/medical problems?_____

Have you had any operations? Y or N/ what type? _____

Do you smoke? Yes / No Do you drink Alcohol? Yes / No _____

Date of last eye exam _____Location _____

Name of Family Doctor _____ Phone #_____

Insurance Information If Applicable

Insurance Plan_____

Whose name is the plan under? _____Members date of birth_____

Policy holder social security #_____

ID #_____ Group #_____

WE CANNOT TAKE YOUR INSURANCE AND YOU WILL NEED TO PAY IN FULL TODAY

IF YOU DO NOT SIGN BELOW

I authorize payment of my benefits to be made directly to the physician listed above, and will be responsible for any denial of claims if my insurance denies payment. I authorize the release of any medical information in order to process any claims

X _____