**Fort Pierce Vision Care**
**Dr. Paul B. Moll, O.D.**
**Dr. Fonda M. Moll, O.D.**
**Dr. Mark Moll, O.D.**
828 South U.S. 1; Fort Pierce, FL 34950

PATIENT INFORMATION (Please print)

LAST **FIRST** M.I.

Name__________________________________________ Birth date _____________Age____
If Married, Name of Spouse__________________If Child, Parents Name_________________
Address____________________________________________________Apt#____________
City____________________State______Zip_________Home phone____________________
Occupation_________________________mobile phone or text # ________________________
SS#_____________________
Person to contact in case of emergency________________________Phone#_______________

**Health History**

Reason for today's eye exam:_______________________________________________________
Last complete eye exam_________________By Doctor_______________________________
Last physical exam_____________________By Doctor_______________________________

**PLEASE CHECK ONLY ITEMS THAT APPLY**

**Do you or any close blood relative have any history of the following conditions?**

| | Self | Family |
|---|---|---|
| Arthritis | ____ | ____ |
| Diabetes | ____ | ____ |
| Heart Disease | ____ | ____ |
| High Blood Pressure | ____ | ____ |
| Thyroid disease | ____ | ____ |
| Lung/breathing | ____ | ____ |
| Stroke | ____ | ____ |
| Cancer | ____ | ____ |
| Glaucoma | ____ | ____ |
| Cataract | ____ | ____ |
| Turned/lazy eye | ____ | ____ |
| Blindness | ____ | ____ |
| Kidney Disease | ____ | ____ |
| Sinus Problems | ____ | ____ |
| Other eye disease | ____ | ____ |

**DO YOU PRESENTLY HAVE ANY OF THESE CONDITIONS?**

| | |
|---|---|
| Blurred vision | ____ |
| Hay fever/Sinus | ____ |
| Pregnant | ____ |
| **MEDICAL COND. RELATED TO EYES:** | |
| Eye injury | ____ |
| Eye surgery | ____ |
| Headache | ____ |
| Double vision | ____ |
| Eyes water | ____ |
| Eyes itch | ____ |
| Floaters | ____ |
| Light sensitive | ____ |
| Flashes of Light | ____ |
| Eye Lid Problems | ____ |
| Red eyes | ____ |

List any other medical conditions_____________________________________________

Please list **all allergies**_____________________________________________________
Please list **all medications**_____________________________________________________

Have you ever worn contact lenses? Yes No
If yes, what type? Soft Hard Brand name______________________________________
Are you interested in contact lenses? Yes No Colored contacts? Yes No

**Authorized Patient Signature**

I authorize the release of any medical or other information necessary to process this claim and determine benefits payable for related services. I also request payment of government or insurance benefits, to either myself or on my behalf, to Dr. Moll for any services furnished to me by Dr. Moll. I grant Dr. Moll my permission to provide the necessary medical treatment. I have received and read Fort Pierce Vision Care's notice of privacy practices.

**Lifetime Patient Signature**_________________________________ **Date** _______________
(Or parent/legal guardian if patient is a minor)