UPTOWN EYE CARE
Dr. Steven C. Moore & Associates

# Welcome to our office!

## Please print legibly

NAME_____ DOB _____

ADDRESS_____

EMAIL (for updated appointment information)_____

Contact phone numbers (please circle preferred method of contact):

HOME_____ CELL_____ WORK_____

SSN (for insurance purposes)_____

EMPLOYER_____ TITLE_____

REFERRED BY_____

**HIPAA ACKNOWLEDGEMENT**

I acknowledge that I have received a copy of Dr. Steven C. Moore & Associates' NOTICE OF PRIVACY PRACTICES.

SIGNATURE_____ DATE_____

PRINT NAME_____

Relationship to patient (if not self)_____

**PATIENT RESPONSIBILITY STATEMENT**

I understand that though Dr. Steven C. Moore & Associates' office calls to verify insurance eligibility and benefits, this is not a guarantee of payment. I allow assignment of my insurance benefits to Dr. Steven C. Moore & Associates. I will be financially responsible for payment of all charges incurred for services received from this office and any procedures not covered by insurance.

SIGNATURE_____ DATE_____

***Patients under 18 years of age:***

Parent/guardian gives permission for the patient's eyes to be dilated so their doctor may examine the full ocular health of this patient.

Circle one: YES NO PREFERS OPTOMAP IMAGING

SIGNATURE_____ DATE_____ Relationship to patient _____

*Signatures have no expiration