Registration History *The office of:* Roger A. Moore, O.D.

Patient's Name____Date________________

Street Address________________________________ SS # (last four) XXX-XX-__________

City / State / Zip____________________________________Height_____Weight_____

Home Phone (___)__________ Work Phone (___)__________ Cell Phone (___)____________

Occupation____________________________Employer____________________________

Date of Birth____________________Spouse or Guardian______________________________

Email address____

Do you wear contact lenses? Y/N Type(Soft or Firm)? ________ Are you interested in Contact Lenses? Y/N

Are you Interested in Laser Vision Correction? Y/N Are you interested in Corneal Refractive therapy? Y/N

Federal regulations require all health care providers to inform you of our privacy policies and how your health care information may be used. In summary, there are times when personal information about your health may be revealed to other parties, such as; your insurance company when submitting a claim or when they audit our records; our labs when ordering materials or tests for you; with other doctors who have or will treat you; with government agencies when required by law (court subpoenas, contagious disease reporting, notices from the FDA about drugs or medical devices, criminal investigations and/or suspected abuse, etc.); with collection agencies or lawyers for unpaid fees; with pharmacies when prescribing medications for you; documenting workers compensation claims and treatment. Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your eye care. In addition, a copy of our electronic records is kept off site. We will not share your health information with unauthorized people. When transmitting your personal information electronically, we use secure, 128-bit encryption software.

You have certain rights about the use of your health care information. You have the right to ask us not to use it for certain circumstances, you have the right to photocopies of your records for a nominal fee, you have the right to amend your health information if you think it is incorrect, you may ask us to communicate with you in a confidential way, and you may ask for a list of how we have disclosed your information in the past six years, unless those disclosures were for routine office operations. In addition, you may view and obtain a complete copy of our privacy policy if you so desire.

You have the right to complain to the U.S. Department of Health and Human Services, Office for Civil Rights, if you think we have not properly respected this privacy. You may also complain to Dr. Moore at this address, or by calling 203-426-2727. Please initial here__________, indicating that you have seen and understand this information.

Signature on file

I authorize the use of this form on all my insurance submissions. I authorize release of information to all my insurance companies or their representatives. I permit a copy of this authorization to be used in place of the original. I authorize payment direct to my doctor. I understand that any balance or service not covered by my insurance will be my responsibility. Payment for non-covered services is due at time of service. Unpaid balances more than 90 days overdue are subject to $5 per month service charge.

Signature____

Print name____Date____________________

Name and Date of Birth of Policy Holder____