



Connections of Moorhead, Inc.

810 4th Ave. S., Suite 156, Moorhead, MN 56560

Phone: 218-233-8657 Fax: 218-236-5983

Optical Evaluation

Client: _____ Date of Examination: _____

Clients Date of Birth: _____

Authorization to Release Information

I, _____,

(Client)

(Address)

give permission to _____ to provide and exchange information

(Dentist's Name)

regarding my examination with Connections – SILS for a period of 1 year.

1. Eyes: Visual/Acuity 2. Evidence of Disease:

Right Eye ___/___

Right Eye: ___/___

Left Eye ___/___

Left Eye: ___/___

3. Summary of Examination:

4. Treatment Provided:

5. Recommendations/Special Instructions:

Is further treatment needed? YES NO

If yes, when is next appointment scheduled? Date: _____ Time: _____

Physician's Signature: _____

Physician's Name (Printed): _____