# Patient Information Form

All information is confidential. We need the following information to provide you with the best optometric care.
Please Print.

Patient Name_____
Date of Birth:_____/_____/_____ Age: _____ Gender: Male / Female
Address: _____ City_____ State____ Zip Code_____
Contact info: Home_____ Work_____
Cell:_____ E-mail _____
Employer: _____Occupation: _____

**Insurance Information (Please Complete If You Will Be Using Insurance)**

Vision Insurance:_____ Medical Insurance:_____
Member ID #: _____
**Primary Member Information:**
Name: _____ Relation to Patient: _____
SSN: _____-_____-_____ Date of Birth: _____/_____/_____

**Personal History**

Reason for this visit_____
When and where was your last eye exam?_____
Current Family Physician_____
Current Medications_____
Allergies (Include medication allergies) _____

Cataracts Y / N Self or Relative_____ Heart Disease Y / N Self or Relative_____
Glaucoma Y / N Self or Relative_____ Diabetes Y / N Self or Relative_____
Macular Degeneration Y / N Self or Relative_____ Blindness Y / N Self or Relative_____
Retinal Detachment Y / N Self or Relative_____ High Blood Pressure Y / N Self or Relative _____

| | | | |
|---|---|---|---|
| Blurred Vision | Y / N | Flashers/Floaters | Y / N |
| Double Vision | Y / N | Lazy Eye | Y / N |
| Eye Injury | Y / N | Eye Surgery | Y / N |
| Smoking | Y / N | Thyroid Disease | Y / N |
| Headache | Y / N | Asthma | Y / N |
| Currently Pregnant | Y / N | | |

Do you currently wear glasses? Y/N
Do you currently wear contact lenses? Y/N
Are you interested in contact lenses? Y/N
Are you interested in laser vision correction? Y/N

How did you find our office? Referral Yellow Pages Insurance List Advertisement Internet
Whom may we thank for referring you to us? _____

**Release:** I authorize Dr. Rosa Optometry, Inc. to release any information required for insurance processing. I understand that I am responsible for all charges and fees that my insurance does not pay. I have also read or received a copy of the Privacy Practice Notice (HIPAA).

**Signature:**_____ **Date:**_____