

# PATIENT INFORMATION FORM

ALL INFORMATION IS CONFIDENTIAL. WE NEED THE FOLLOWING INFORMATION TO SERVE YOU WELL.  
PLEASE PRINT.

Patient Name \_\_\_\_\_ Sex: M F  
Street Address \_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Email Address \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Name of Vision Insurance \_\_\_\_\_ Member ID \_\_\_\_\_  
Member Name \_\_\_\_\_

When and where was your last eye exam? \_\_\_\_\_  
Main problem or reason for this visit? \_\_\_\_\_

## Do You Have Any Personal History of The Following?

Blurred Vision	Y	N	Cataracts	Y	N
Double Vision	Y	N	Glaucoma	Y	N
Lazy Eye	Y	N	Diabetes	Y	N
Eye Injury	Y	N	High Blood Pressure	Y	N
Eye Surgery	Y	N	Heart Disease	Y	N
Flashes/Floaters	Y	N	Asthma	Y	N
Headaches	Y	N	Currently Pregnant	Y	N
Smoking	Y	N	Thyroid Disease	Y	N

Current Medications \_\_\_\_\_  
Allergies (Including medication allergies) \_\_\_\_\_  
Current Family Physician: \_\_\_\_\_

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

## Do you have any Family History of the Following?

Glaucoma	Y	N	Macular Degeneration	Y	N
Cataracts	Y	N	Retinal Detachment	Y	N
High Blood Pressure	Y	N	Blindness	Y	N
Diabetes	Y	N	Heart Disease	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 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 (HIPPA).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_