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:**________________________