ROSE TREE CROSSROADS EYE CARE, P.C.

Please print clearly

Appointment Date: _______________
Patient's Name: _____________________________
Street: ______________________________________
City, State, Zip: ______________________________
Home Phone: (______) _____-__________
Work Phone: (______) _____-__________
Cell Phone: (______) _____-__________
Email address: ______________________________
Date of Birth: ____________________ M or F

Occupation: _________________________________
Marital Status: _______________________________
Social Security #: ____________________________
Previous Eye Doctor: _________________________
Last Eye Exam Date: _________________
Type of Insurance: ____________________________
Name of Insured: _____________________________
Social Security # of Insured: ___________________
Date of Birth of Insured: ______________________

Personal Medical History

Current Medications: ________________________
____
____

Drug Allergies: ______________________________
____

	YOU	**FAMILY**
Allergies	NO/YES	NO/YES
Asthma	NO/YES	NO/YES
Arthritis	NO/YES	NO/YES
Cancer	NO/YES	NO/YES
Diabetes	NO/YES	NO/YES
Gastrointestinal Disease	NO/YES	NO/YES
Heart Disease	NO/YES	NO/YES
High Blood Pressure	NO/YES	NO/YES
Respiratory Disease	NO/YES	NO/YES
Thyroid Disease	NO/YES	NO/YES
Cataract	NO/YES	NO/YES
Glaucoma	NO/YES	NO/YES

Eye Injury (specify): ___________________________
Eye Surgery (specify): __________________________
Amblyopia (Lazy Eye) NO/YES
Do you Smoke? NO/YES
Do you Drink Alcohol? NO/YES
Women only:
Are you Pregnant? NO/YES

Do you wear glasses? NO/YES
Do you wear contact lenses? NO/YES
Are interested in contact lenses? NO/YES
If you wear contact lenses, are you satisfied with vision and comfort? NO/YES
Are you interested in refractive surgery? NO/YES
Do you work on computers? NO/YES
Do you spend time outdoors? NO/YES

Do you experience…

Discomfort with your eyes? NO/YES
Dry eyes? NO/YES
Double vision? NO/YES
Headaches? NO/YES
Floaters or flashes of light? NO/YES
Problems with glare or reflections? NO/YES
Sensitivity to light? NO/YES

COPAYS AND OTHER PAYMENTS ARE EXPECTED IN FULL AT TIME OF SERVICE

ALL INSURANCE/S, DISCOUNT PLANS AND GIFT CARDS MUST BE PRESENTED AT TIME OF SERVICE

I assign to **Rose Tree Crossroads Eye Care, P.C.** and to **Dr. Robert Guerra** all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

_________________________________ ____________ ____________
Responsible Party Signature **Relationship** **Date**