Dr. Rosenak's Optical Options, Inc.

Patient Information

Today's Date________________________________
Name_______________________________________
Address_____________________________________
City_________________________State ___________
Zip Code ____________________________________
Home Phone__________________________________
Cell Phone ___________________________________
Work Phone _________________________________
Gender- Male / Female
Date of Birth_______________________________
Patient SSN______-_____-________
E-mail______________________________________
Employer/School ____________________________
Occupation/Grade____________________________
Spouse/Parent Name__________________________
Spouse/Parent Work__________________________

Insurance Information

Vision Insurance______________________________
Subscriber Name______________________________
Subscriber SSN______-_____-_______
Subscriber DOB_____________________

Primary Medical Insurance_____________________
Subscriber Name______________________________
Subscriber SSN______-_____-_______
Subscriber DOB_____________________

Do you participate in a Flex Spending Account?
___ Yes ___No
How will you settle your account today?
___Cash ___Check ___Credit/Debit

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company.
Statement of Financial Responsibility: I understand I am responsible to pay for services rendered, including costs of collection in the event of default, I further understand that if a payment is 30 days past due a finance charge will be added monthly to the account until paid in full. I have read this statement, understand it and agree to the conditions. Authorization is hereby granted to Dr. Rosenak's Optical Options, Inc. to release medical records and such information as may be requested for the completion of my claims to my insurance carrier. I further authorize payment for medical benefits to be made directly to Dr. Rosenak's Optical Options, Inc.

Signature:_________________________________

Patient Medical History

Name of Family Physician ____________________
Date of Last Physical Check-up________________

CURRENT MEDICATIONS (Rx or OTC)
List name of medications including eye drops, vitamins, & birth control pills__________________
____
____
____

Allergies to medications? ___Yes ___No
If so, what medications?______________________
____
Do you use cigarettes/tobacco, alcohol, or other substances? ___Yes ___No
Have you had any surgeries?___________________

Have you ever been diagnosed or treated for the following health problems?

	YES	NO
Allergies……………………	___	___
Arthritis…………………….	___	___
Blood/Lymph………………	___	___
Bronchitis…………………..	_ __	___
Cancer………………………	___	___
Cholesterol…………………	___	___
Diabetes…………………….	___	___
Digestive………………….....	___	___
Ear/Nose/Throat…………….	___	___
Endocrine..…………………..	___	___
Eczema/Rashes……………...	___	___
Fatigue………………………	___	___
Fevers………………………	___	___
Genitourinary ………………	___	___
High Blood Pressure………...	___	___
(Skin) .………………………	__ _	___
Kidney………………………	___	___
Muscle/Bone………………....	___	___
Neurological…………………	___	___
Psychological………………..	___	___
Respiratory…………………..	___	___
Sinus…………………………	___	___
Throat Infections…………….	___	___
Thyroid………………………	___	___
Unusual weight loss/gain……..	___	___

Dr. Signature_______________________________
Date _________________________

Acknowledgement of Receipt

I acknowledge that I have received a copy of the notice of privacy practices for Dr. Rosenak's Optical Options, Inc.

Date______________________________________

Patient Name______________________________

Signature_______________________________________

Patient Eye History

Date of Last Eye Exam_______________________

By Whom? _________________________________

Have you ever tried contact lens? Yes____No____

Do you currently wear contacts? Yes____No____

Brand worn________________________________

Solution used ______________________________

Are you satisfied with the vision and comfort of your contacts? Yes_____ No_____

Would you like color or extended wear contacts?
Extended Wear_____ Color_____

If you wear bifocal lenses, do the lines or head tilting bother you? Yes____ No____

Do you have any problems or concerns with your current contact lenses or glasses?

____

____

____

Patient Eye History Cont.

Have you ever experienced, been diagnosed or treated for any of the following?

___Blurry Vision ___Burning

___Cataracts ___Corneal Abrasions

___Crossed Eyes ___ Double Vision

___Eye Infections ___Eye Injury

___Flashes of Light ___Floaters/Spots

___Glaucoma ___Grittiness

___Headaches ___Iritis / Uveitis

___Trouble seeing at night ___Lazy Eye

___Macular Degeneration ___Occasional Dryness

___Retinal Detachment ___Sunlight Sensitivity

___Tearing ___Itchiness

___Uncomfortable glasses ___**None**

___Other_________________________________

Family Medical History

Is there a family medical history for any of the following conditions?

Relationship
(Mother, Father, Etc.)

Blindness _______________________________

Cataracts________________________________

Corneal Problems__________________________

Diabetes_________________________________

Glaucoma________________________________

Heart Disease_____________________________

Lazy Eye_________________________________

Macular Degeneration______________________

Retinal Problems__________________________

Lifestyle Questions and Family History

Do you…..(Check if your answer is yes)

___work at a computer?

___think you might benefit from thinner lighter lenses?

___have interest trying the newest contact lens design?

___spend time outside? ____Hrs/Week

___have prescription sun wear?

___prefer not to wear your glasses at times?

___want information on Laser Vision Correction surgery?

___have more than 1 pair of current RX eyewear?

___have children?

___have family members in need of eyewear?

VERY IMPORTANT! NEW PATIENTS ONLY:

Who may we thank for referring you to our office?

Name of friend or relative____________________

If not referred by a friend/relative how did you choose our office?___________________________

You can stay up to date with all the latest news and information by visiting us on Facebook or going to our website:

www.drrosenak.com