Patient Information

Legal Name:_____

Date of Birth:_____
SS#_____

Marital Status: Single / Married / Widowed / Divorced **Gender:** Male / Female

Street Address/PO Box:_____

City,State,Zip:_____

Home Telephone:_____ **Cell Phone:**_____

Email Address:_____

Primary Care Dr:_____**Referring Dr:**_____

Pharmacy:_____**City:**_____**Phone:**_____

Occupation:_____
Employer:_____

Current Medical Insurance(s):_____

Policy Holder Name:_____ **Date of Birth:**_____

How did you hear about Dr. Rom:_____

Emergency Contact Information:

Name:_____
Relationship:_____

Home Telephone:_____Cell Phone:_____

I certify that I,and/or my dependant(s), have insurance coverage with those listed above and assign directly to Insight Eye Center, Dr. Michael E. Rom, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named practice may use my health care information and my disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services. I acknowledge that I understand the Privacy Policies of this office. (A copy of the Notice of Privacy Practices is available upon request.)

Patient Signature:_____Date:_____

INSIGHT EYE CENTER

Medical History

Patient Name:_____
Date:_____

Date of Birth:_____
Doctor who performed your last eye exam:_____

Date of last eye exam:_____

Is there any Family History (including yourself) of:

Glaucoma Yes/ No If yes, who_____

Macular Degeneration Yes / No If yes, who_____

Cataracts Yes / No If yes, who_____

Have you ever had an eye operation or serious injury? Yes / No
Explain:_____
____

_____
____

Do you have, or have you ever had any of the following:

High Blood Pressure	Yes / No	**Congestive heart failure**	Yes / No
Diabetes	Yes / No	**Rheumatoid arthritis**	Yes / No
Asthma	Yes / No	**Thyroid disease**	Yes / No
Stroke	Yes / No	**Cancer**	Yes / No
Anxiety	Yes / No	**Depression**	Yes / No

List Any Other Medical Conditions:_____

_____
____

Smoking Status: Non Smoker / Current Smoker / Previous Smoker

Do you drink Alcoholic Beverages? Yes / No
Frequency:_____

Do you use any Recreational Drugs? Yes / No **Please List:**_____

INSIGHT EYE CENTER

List all Prescription Medications that you take:

_____
_____
_____

_____
_____
_____

_____

List all OTC Medications, Herbal Supplements, or Vitamins that you take:

_____
_____
_____
_____
_____
_____

Are you Allergic to any Medications / Anesthetics/ Foods:
Yes / No

Please List:_____
_____
_____
_____
_____

Patient Name:_____**Date:**_____