

**Town Center Eye Care
Dr. Lauren Rubin
Optometrist**

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Date _____

Last Name (Mr. Mrs. Miss. Dr.) _____ First Name _____ MI _____

Preferred Name _____ Soc. Sec (Last 4) # _____ Date of Birth _____ Age _____ Gender M F

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Email Address _____

Employer Name _____ Work Phone # _____

Occupation _____ Full Time Student Y N

Responsible Party Name (if minor) _____

Emergency Contact Name _____ Phone # _____

How did you hear about our practice? _____

INSURANCE INFORMATION

Primary Insurance _____

Name of Primary Insurance Holder _____ Date of Birth _____

Relation to Patient _____ ID # _____

Secondary Insurance (if any) _____

Name of Primary Insurance Holder _____ Date of Birth _____

Relation to Patient _____ ID # _____

Please provide insurance card(s) to the office in order for them to make a photocopy.

VISUAL AND HEALTH INFORMATION

What is/are the reason(s) for your visit today? (Please circle all that apply)

General check-up	See floaters or spots	Blurred distance vision
New glasses	See flashes of light	Blurred intermediate vision
Lost or broken glasses	Eyes feel dry	Blurred near vision
Double vision	Eyes are red	Want contact lenses
Headaches	Eyes itch	Contact lens check-up
Eyes water	Pain in eyes	Bifocal contact lenses
Eyes burn	Other: _____	

Do you or have you ever worn glasses? Y N If yes, what for? Distance / Near / All the time

Do you or have you ever worn contact lenses? Y N If yes, what type? Soft / Gas Permeable / Toric

If you wear disposable lenses, how often do you replace them? _____

Approximate date of your last eye exam? _____

Are you interested in Laser Vision Correction? Y N

VISUAL AND MEDICAL HISTORY

Have you had any of the following eye conditions? (Please circle all that apply)

Glaucoma	Eye surgery	“Lazy Eye” (Amblyopia)
Cataracts	Eye injury	Retinal Disorders (macular degeneration, holes, tears)
NONE	Other: _____	

Has anyone in your immediate family had any of the above conditions? Y N

If yes, what relative and what condition(s)? _____

Do you have any problems with the following systems or conditions? (Please circle all that apply)

Allergy	Blood/Lymph	Psychiatric
Cardiovascular	Immunologic	Respiratory
Endocrine/Diabetes	Integumentary (skin)	Pregnant/Nursing
Gastrointestinal	Musculoskeletal	NONE
Genitourinary	Neurological	Other: _____

Are you currently taking any medication? Y N If yes, please list. _____

Do you have any allergies? Y N If yes, please list. _____

Do you have any allergies to medication(s)? Y N If yes, please list. _____

I authorize Rockville Eye Care, LLC (DBA Town Center Eye Care) to release any information requested with respect to insurance claims, prescription authorization, and bills reflective of services rendered by the provider of service. I also authorize that payment of insurance benefits for services rendered are made to Rockville Eye Care, LLC (DBA Town Center Eye Care). I understand that I am responsible for any charges not covered by this authorization. I permit a copy of this authorization be used in place of the original.

Signature _____ Date _____

I acknowledge that a copy of the Notice of Privacy Practices for Rockville Eye Care, LLC. has been made available to me. I acknowledge that Rockville Eye Care, LLC has posted the Notice of Privacy Practices and copies are available upon request.

Patient Name _____ Date _____

Signature _____

Doctor's Initials _____ Date _____

UPDATED Initials _____ Date _____

Initials _____ Date _____