Welcome to Rabbitt Family Vision Center

We appreciate the opportunity to care for your eye care needs!
Please furnish us with the following information so that we may better serve YOU!

Last Name: _____ First Name: _____ MI: _____
Address: _____
City: _____ State: _____ Zip: _____ Sex: M F
Date of Birth: _____/_____/_____ Age: _____ SS#: _____ / _____ / _____
Phone: _____/_____/_____ Cell: Y N Race:_____ Ethnicity: Hispanic Non-Hispanic
Email Address _____
Emergency Contact: _____ Phone Number: _____
If minor, name of Parent:_____

List ALL Insurance: _____ ID # _____
Primary Card Holder Name: _____ SS# _____/_____/_____ DOB _____
Primary Card Holder 's Place of Employement _____

Has anyone in your household ever been a patient here? Who?_____
Has a specific problem brought you in to see us today? Y/N If yes explain _____

Personal Eye Operation

Have you had any eye operations? Y / N Type:_____ L / R Date: ____/_____/_____
Have you had any eye injuries? Y / N Type:_____ L / R Date: ____/_____/_____
Circle any **you** have been diagnosed with: Glaucoma Cataracts Dry Eyes Blurred

Personal Information

Approximate Date of Last Eye Exam: _____/_____/_____ By Dr. _____
What is your general health? Good Fair Poor
Current Medications: _____
List Allergies & Reaction: _____

Y / N Diabetes Y / N High Blood Pressure Y / N High Cholesterol
How many years: _____ How many years: _____ How many years: _____

Family History Please circle all that apply

High Blood Pressur	N/A	Mother	Father	Brother	Sister	**Macular Degeneration**	N/A	Mother	Father	Brother	Sister
Diabetes	N/A	Mother	Father	Brother	Sister	**Retinal Detachment**	N/A	Mother	Father	Brother	Sister
Glaucoma	N/A	Mother	Father	Brother	Sister	**Cataracts**	N/A	Mother	Father	Brother	Sister

Authorization I grant the following individuals permission to receive confidential information on my behalf:

By signing below, I acknowledge that I have received Rabbitt Family Vision Center's Privacy Notice and the above information is correct to the best of my ability. I understand that whatever my insurance doesn't cover I will be responsible for.

Signature _____ Date _____ / _____ / _____
Signature _____ Date _____ / _____ / _____
Signature _____ Date _____ / _____ / _____