Date: ___________ Home Phone: (____) ____________

Patient: ____ (M / F)
Last Name First Name Middle Initial

Home Address: ________________________City: ___________St: ___ Zip: ___________

Birth day(MM/DD/YYYY): _______ Cell Phone: (___) __________Bus Phone: (___) _________

Occupation: ___________________________ E mail _________________@____________

Special Visual Needs at Work: ____

Known Medical Problems: ____

Medications: ____Allergies: _____________

Do You or anyone in your family have: Diabetes (Y N), High Blood Pressure (Y N), or Glaucoma (Y N) ? (Please list) ____

Do you ever have? Floaters(Y N), Itchy Eyes(Y N), Eye Twitch (Y N), Red Eyes (Y N)

Do you? Smoke (Y N), Drink Alcohol (Y N), Recreationally Use Drugs (Y N)

Whom may we thank for referring you? ____

Signature on File

I understand that if the insurance company does not pay Dr. Rubinstein's fees, that I am responsible for them.
I authorize the use of this form on all my insurance submissions.
I authorize release of information to all my insurance companies.
I authorize the doctor to act as my agent to obtain payment from my insurance companies
I authorize payment directly to my doctor.
I permit a copy of this to be used in place of the original.

Signature: ____

Insurance Co: ________________ **ID #** _________________ Referral needed Y/N

Only if Child or Spouse: Insured's Name: _____________**DOB:** ____/____/_____ **SS#** ______-____-______