RVC Optometric Associates, P.C.

Dr. Diana Grishina O.D. Dr. David L. Leibstein O.D. Dr. Jack A. Facchin O.D.
282 Sunrise Highway
Rockville Centre, NY 11570

Today's Date_____

Patients Name_____ Birthdate_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ Social Sec. #_____

Occupation_____ Place of Employment_____

How Did You Hear About Our Office? _____ Email Address_____

Insurance Coverage:
Major Medical_____ I.D. Number_____

Policy Holder Name_____ Policy Holder D.O.B._____

Vision Care Coverage_____ I.D. Number_____

Policy Holder Name_____ Policy Holder D.O.B._____

Reason For Visit_____

Last Eye Exam_____ By Whom_____
Last Physical_____ By Whom_____

Please check off any conditions which you or any of your family members are being treated for:

Relative	**Self**		**Relative**	**Self**	
____	____	Diabetes	____	____	Lung Problems
____	____	Hypertension	____	____	Liver Problems
____	____	Heart Problems	____	____	Kidney Problems
____	____	Thyroid Problems	____	____	Blood Problems
____	____	Skin Infections	____	____	Arthritis
____	____	Glaucoma	____	____	Cancer/ Tumors
____	____	Lazy Eye	____	____	Cataracts
____	____	Shingles	____	____	High Cholesterol
____	____	Auto Immune Disease	____	____	Macular Degeneration

- Have you experienced any of the following conditions with your eyes? (Y/N)
  ____ Double Vision ____Loss of Vision ____Flashing lights ____Floating spots _____ Pain around eye
- Describe any eye injuries or surgeries you have had, along with the treatment received.
  _____
  _____
- Describe any surgeries you have had to treat any health problems.
  _____
- Please list any medications you are presently taking (including: birth control and over-the-counter)
  _____
- List any allergies you presently have (including: medications, shellfish, seafood and iodine products)
  _____

Insurance Authorization and assignment of benefits:
I hereby authorize RVC Optometric Associates to furnish to my insurance carrier any information concerning my condition/ treatments and hereby assign RVC Optometric Associates all payments for services rendered to myself or dependents. I undersign that I am responsible for any amount not covered by my insurance.

Signature _____ Date _____