

**WELCOME to Dr. Robert Monetta Optometry/Eyes in Disguise Optometry**

(Please Print) \_\_\_\_\_ Date \_\_\_\_\_

Patient \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone ( ) \_\_\_\_\_

D. L. State & # \_\_\_\_\_ SS# \_\_\_\_\_ E-Mail \*\* \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_

Business Phone \_\_\_\_\_ Referred By \_\_\_\_\_

\*\* We kindly request an email address to remind you when it's time for your annual exam, and when your glasses or contact lenses are ready. Due to medical privacy laws, we will not share this with anyone. \*\*

**MEDICAL HISTORY**

Date of last vision exam \_\_\_\_\_ Previous Eye Doctor \_\_\_\_\_

Past injury or surgery to eyes? Yes No Please Describe: \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury? \_\_\_\_\_

Have you had a physical exam in the last 12 months? Yes No Physician's Name \_\_\_\_\_

Please describe if there were any significant findings \_\_\_\_\_

List any medications you are taking, reason, and start date \_\_\_\_\_

Are you allergic to any medications? If yes, please list \_\_\_\_\_

Do you drive? No Yes Do you have visual difficulty when driving? No Yes If yes please describe: \_\_\_\_\_

Please list an emergency contact who is not living with you:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**FAMILY and HEALTH HISTORY**

Please note any personal or family history (parents, grandparents, siblings; living or deceased) for the following conditions:

CONDITION	YES	NO	Details	RELATIONSHIP TO YOU
Blindness				
Cataracts				
Crossed Eyes				
Glaucoma				
Macular Degeneration				
Retinal Detachment/Disease				
Cancer (list type)				
CONDITION	YES	NO		RELATIONSHIP TO YOU

Accident/Head Trauma (list type, year)			
CARDIOVASCULAR: (high blood pressure, hypercholesterolemia, etc.)			
NEUROLOGICAL (Stroke, aneurysm, numbness, headache, seizures, neurosurgery, paralysis, etc.)			
ENDOCRINE (diabetes, hypothyroid, hyperthyroid, etc.)			
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)			
SKIN (cancer, rosacea, dryness, eczema, psoriasis, growths, rash, etc.)			
PSYCHIATRIC (anxiety, depression, insomnia)			
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)			
GASTROINTESTINAL (Crohn's, ulcers, hernia, etc.)			
BLOOD/ LYMPH (bleeding, anemia, problems related to blood transfusion, etc.)			
GENITAL, KIDNEY, BLADDER (painful or frequent urination, kidney disease, yellow jaundice, etc.)			
FEMALES: Are you pregnant or nursing?			
MUSCLES, BONES, JOINTS (arthritis, joint pain, swelling, cramps, etc.)			
EARS, NOSE, THROAT (hard of hearing, dry mouth, etc.)			
Smoking tobacco			
Other			

**ACCOUNT RESPONSIBLE**

*Payment is expected when services are rendered.*

There is a 1½ % monthly service charge for balances after 30 days. The patient is responsible for any legal and related expenses involved in the collection of past due accounts.

Credits on materials are issued as store credits only. There are no credits on custom or prescription items. There is a restocking fee for any returned materials. There is a charge for additional tests and contact lens evaluation.

There is a \$50.00 late cancellation fee for appointments that are changed or canceled within 24 hours of your appointment time.

Method of payment:        Self                                  Parent

Vision Insurance company and group number: \_\_\_\_\_

Name, Date of birth, and Social Security number for Primary Insured: \_\_\_\_\_

Signature of person responsible for payment: \_\_\_\_\_ Date: \_\_\_\_\_

*Please fax back to Dr. Robert Monetta Optometry (415)239-1994 or  
Eyes in Disguise Optometry (415)474- 474-7345  
Thank You*