Welcome to Racine Optical Co.

Date:_____

Last Name:_____First Name:_____ MI:_____

Date of Birth:_____ Address:_____

City:_____ State:_____ Zip:_____

Best Phone:_____ SSN:_____

Email: _____ Can we send emails or text messages to you ?____

Married: Yes___ No___ Emergency Contact Person:_____

Name of Medical Ins and ID #_____

Name of Vision Ins and ID # _____

Insurance Subscriber's Name & Date of Birth _____

Main purpose of your visit today? Eye Glasses Contacts Eye Health

Dr. Rosenberg recommends the **OptoMap** for the best 3-D inside the eye health exam for $39.00

OR we can use the **Dilation Drops**. Please circle your preference.

Name of primary care physician_____

Date of last physical exam_____

Current medications (Rx or over the counter)

_____

_____

_____

_____

Do you have Any Allergies to Medications ? Yes No

if yes please list_____

Date of last eye exam_____

OVER PLEASE

Do YOU or any of your FAMILY have the following conditions?

Conditions	***YOU***	***FAMILY***	***Parent, Grandparent, Sibling***
Blindness	____	_____	_____
Cataracts	____	_____	_____
Glaucoma	____	_____	_____
Lazy Eye	____	_____	_____
Retinal problems	____	_____	_____
Diabetes	____	_____	_____
Macular Degeneration	____	_____	_____

Have YOU ever been diagnosed or treated for any of the following?

Corneal Abrasion	____	Allergies	____
Eye Injury	____	Cancer	____
Eye Infection	____	High Blood Pressure	____
Iritis/Uveitis	____	High Cholesterol	____
Lasik/RK	____	Thyroid Problems	____
Retinal Detachment	____	Other Medical Issues	_____

Do YOU experience the following?

___Blurry Vision	___Burning Eyes	___Tearing	___Headaches
___Double Vision	___Flashes of Light	___Grittiness	___Floaters
___Itchy Eyes	___Dryness	___Sunlight Sensitivity	
___Crossed Eye / Eye Turn	___Trouble Seeing at Night	___Uncomfortable Glasses	

Do YOU

____Work at a computer? _____ Hours/Day
____Think you'd benefit from thinner, lighter lenses?
____Spend time outdoors?
____Have prescription sunglasses?
____Want information on Laser Vision Correction surgery?
____Have children or family in need of eye care?
____If you wear bifocals, do the lines or head tilting bother you?

Payment Policy:
Eye-wear and Contact lenses-50% down-payment is required on all purchases with remaining balance to be paid at dispensing. Every pair of eye-wear is custom made for your eyes, so returns are subject to a 30% restocking fee.

Professional Services- Payment in full is expected at the time of service. If you have vision and/or health insurance, we will submit a claim for you. The balance on your account will remain your responsibility.

I agree and understand that regardless of my insurance status, I am ultimately responsible for the balance on my account for any service rendered. I authorize the release of any information necessary to process my insurance claim.

Signature_____ Date_____