Sound Shore
VISION CENTER

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# _____-____-_____