# ROTTMAN EYE CARE

RANDY ROTTMAN, MD AND ASHLEY FORD, OD

**Patient's Full Name:** ________________________________________________

**Mailing Address:** ________________________________________________

**City:** ______________________ **State:** ____________ **Zip Code:** ____________

**Home Phone:** ________________ **Cell Phone:** ________________ **Leave Message? Y N**

**Date of Birth:** ______________ **Sex: M F** **SS Number:** ____________________

**Email Address:** ________________________________________________

**Marital Status: Married Single Divorced Widowed Separated**

**Primary Care Physician:** ________________________________________________

**Employment Status: FT / PT Unemployed Retired Self-employed Student**

**Patient's Employer:** ____________________ **Phone Number:** ____________________

**Preferred Language: English Spanish Other:** ____________

**Preferred Communication: Telephone Email Mail**

**Race: White American Indian/Alaskan Native Asian**
**Black/African American Hispanic Hawaiian/Other Islander**

**Primary Insurance:** ____________________________ **ID Number** ______________

**I, ______________________, authorized Rottman Eye Care to discuss my medical records with the following individuals:**

________________________________________________

****Rottman Eye Care does not bill vision insurance plans. Rottman Eye Care is a medical office and will only bill medical insurance plans. Please understand that if you elect to have a refraction (testing for new glasses prescription), it may not be a covered benefit under your medical insurance plan. Rottman Eye Care will bill you $47 for the refraction in the case that it is not a covered benefit.**

**COMPLETE THE FOLLOWING, ONLY IF PATIENT IS UNDER 18 YEARS OF AGE**
**Parent or Legal Guardian's full name:** ________________________________
**Relationship:** ______________ **Date of Birth:** __________ **SS Number:** __________
**Address (if different from above):** ____________________ **Phone:**______________
**I, ______________, DO / DO NOT authorize Rottman Eye Care to provide services to ________ without my presence (or other designated adult) in the exam room.**

**If applicable, indicate any other adults that may accompany your dependent into the exam room.**

**Name and Relationship:**________________________________________________

1190 Bookcliff Ave., Suite 102 Grand Junction, CO 81501
phone: 970.242.3323 | fax: 970.242-8774 | info@rottmaneyecare.com

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## HEALTH QUESTIONNAIRE

**Date: ___________ Patient's Name: ________________________________ Date of Birth: ____________**

**Primary Care Physician _________________________________________________________________**

**Were you referred to our office? YES NO If yes, physician name: ________________________**
**What is the reason for your visit today? ___________________________________________________**
**Is this visit for a work-related injury? YES NO**
**Do you wear glasses? YES NO Do you wear contacts? YES NO**
***If yes, please bring your most recent prescription**

**Check any of the conditions that apply to you (even if controlled by medication):**

- ❑ Diabetes**:** Type I or II, year diagnosed: _______
- ❑ High Cholesterol
- ❑ Cancer, type**:** _________________
- ❑ Asthma
- ❑ Thyroid Disease
- ❑ Lung Disease
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Arthritis
- ❑ AIDS/HIV Positive
- ❑ Hepatitis, type _____
- ❑ Other________________________________

**Have you ever been diagnosed with any of the following ocular conditions?**

| | RIGHT EYE | LEFT EYE |
|---|---|---|
| ❑ **cataracts ……………………………………………………..** | ❑ | ❑ |
| ❑ **glaucoma …………………………………………………….** | ❑ | ❑ |
| ❑ **macular degeneration ……………………………………….** | ❑ | ❑ |
| ❑ **retinal tear ………………………………………………...** | ❑ | ❑ |
| ❑ **retinal detachment ………………………………………..** | ❑ | ❑ |
| ❑ **other _________________________________________** | ❑ | ❑ |

**Are you using any over the counter or prescription eye drops? YES NO**
**If yes, please list: ______________________________________________________________**

**List all medications, vitamins, and supplements that you currently take. Include dose and directions:**

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Do you have medicine/non-medicine allergies: YES NO**
**If yes, please list with reaction: ______________________________________________________**

**Do you have a FAMILY history of eye problems?**

- ❑ **Crossed eyes, who: _________________**
- ❑ **Diabetic eye disease, who: ___________**
- ❑ **Glaucoma, who: ____________________**
- ❑ **Retinal issues, who: ________________________**
- ❑ **Retinal detachment, who: ___________________**
- ❑ **Macular degeneration, who: _________________**

**Do you currently smoke: YES NO Former smoker, quit date: ___________**
**Do you drink alcohol: YES NO Type, amount, and frequency: _____________________________**



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