Dr. Barry Mozlin
Information Sheet

Today's Date: _____ Date of birth: _____ Your age today: _____
Dr./Mrs./Ms./Mr. _____ _____
Last name first name
Do we have a record on file for you: YES NO E-Mail: _____

_____ _____ _____ _____
Address City State Zip
Phone: _____ _____ _____
Home work cell
Emergency contact name and phone number: _____
Social Security: _____ _____ _____ Driver License: _____ State: _____
Were you referred by anyone? _____
Occupation: _____
Employer:_____
Vision Insurance: _____
Medical Insurance: _____

Please allow us to make a copy of both your vision and medical insurance cards.

What is the main reason you are visiting us today? _____
_____

Do you currently wear: glasses: Y N contact lenses: Y N Rx sunglasses: Y N
With your current Rx, do you suffer from: (check any that apply)
Headaches _____ computer eyestrain_____ dry eyes _____ double vision _____
poor distance vision _____ poor near vision _____ glare at night _____
light sensitivity _____ flashing lights _____ other (specify)_____
Do you have allergies to medications or anything else? Y N If yes, to what? _____
_____
Are you taking any medications? Y N If yes, please list: _____
_____
Have you ever had an eye injury or surgery? Y N If yes, describe: _____
_____
Is there any history of any of the following for your family or yourself?
Glaucoma Y N Retinal Detachment Y N High Cholesterol Y N
Cataracts Y N Macular Degeneration Y N Other _____
Diabetes Y N High Blood Pressure Y N Other _____
Do you wish to have your eyes dilated today? Yes _____ No _____
Are you interested in laser vision correction? Yes _____ No _____ Maybe _____
If there is anything else you would like to add to the above information, please do so! _____
_____
_____
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I have received, read, and signed a copy of the records privacy form.

Signature: _____ Date: _____

Thanks for taking the time to fill out this form!