



200 Canal View Blvd., Suite 102, Rochester, NY 14623-2809
Phone: 585.461.5330 ~ Fax: 585.461.9895

PATIENT INFORMATION RECORD

Name: _____ DOB: _____
Address: _____ Age: _____
City: _____ State: _____ Zip: _____
Home (____) _____ Work (____) _____ Cell (____) _____
Email: _____

Marital Status: _____ Social Security: _____ Sex: M F
Employer: _____ Occupation: _____

Do you have a health care proxy? Y N Contact Name: _____
Emergency Contact: _____ Phone: _____
Relationship to patient: _____

Referring Physician: _____ Phone: _____
Address: _____ City: _____ State/Zip: _____
Primary Care Physician: _____ Phone: _____
Address: _____ City: _____ State/Zip: _____

Last bloodwork done: ____/____/____ Lab: _____
(Labs: ACM, SMH, Via-Health, Other)

Last MR/CT done: ____/____/____ Where: _____
(Borg, IDE, SMH, RDI, UMI)

Last visual test: ____/____/____ Type: _____
(field/evoked response/fundus photos)

Are your symptoms related to an accident (auto/work/other)? No Yes

Is yes, please explain nature of accident and see below: _____

**WE DO NOT ACCEPT AND WILL NOT SUBMIT CLAIMS TO
WORKER'S COMP OR NO FAULT INSURANCE.**

Neuro-Ophthalmology Consultants of Rochester
01/17/06

Chart ID: _____