

Allied Gardens Family Optometry, Dr. Rosina Monaco  
5175 Waring Rd. San Diego, Ca 92120 P: (619)583-1000 F: (619) 229-1938

**Welcome back to our office**

**Please take a few moments to answer the questions below**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian name (if patient is a minor)  
\_\_\_\_\_

Address: Street \_\_\_\_\_ City/state \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Which number do you prefer we use? \_\_\_\_\_ Occupation \_\_\_\_\_

Email address: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

I acknowledge that I have been notified of the Privacy Practices of Dr. Rosina Monaco's office

Signature \_\_\_\_\_ Date \_\_\_\_\_

Do you have any of the following? Please circle all that apply:

Blurry Vision	Dry Eyes	Double Vision	Red Eyes	Floating Spots
Flashes of light	Headaches	Itchy Eyes	Glaucoma	Macular Degeneration

Have there been any changes in your overall health since your last visit? \_\_\_\_\_

Are you taking any new medications or have changed your medications? If so please list \_\_\_\_\_

**If we are billing insurance:**

Has your vision insurance changed? Y N

If Y, Name of new insurance \_\_\_\_\_

Has your health insurance changed? Y N

If Y, Name of new insurance \_\_\_\_\_

I authorize Dr. Monaco to release any information necessary to expedite insurance claims. I authorize payment to Dr. Monaco by my insurance plan. I understand that I am responsible for any charges not paid for by my insurance.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date