

WELCOME TO STEIN OPTOMETRIC CENTER

(must be updated at every visit)

PATIENT INFORMATION NEW PATIENT PREVIOUS PATIENT **TODAY'S DATE** _____

Last Name _____ First Name _____ Male Female

Address _____ City _____ State _____ ZIP _____

Birthdate _____ Age _____ Home/Cell Phone _____ Work Phone _____

Email _____ Occupation _____ Employer _____

REASON FOR TODAY'S VISIT

- | | |
|---|---|
| <input type="checkbox"/> Glasses Exam / Routine Eye Examination | <input type="checkbox"/> Retinal photo (for monitoring patients with high blood pressure, diabetes, glaucoma, macular degeneration, etc.) |
| <input type="checkbox"/> Contact Lens Exam and Lenses | *** Additional fees will apply. |
| <input type="checkbox"/> Refractive Surgery (LASIK) Evaluation | <input type="checkbox"/> Other _____ |
| Date of Last Eye Exam _____ | |

MEDICAL AND EYE HISTORY

Do you have:

- | | | |
|---------------------|-----------------------------|------------------------------|
| High blood pressure | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Diabetes | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Heart Disease | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| High Cholesterol | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Glaucoma | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Cataracts | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Inherited Diseases | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Allergies | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Any Other Health Problems _____ self family member _____

Any Eye Problems/Surgeries _____ self family member _____

Are you pregnant? Yes No

Did you have **LASIK**? Yes No If yes, when? _____

List any **medications** you are taking _____

Allergies to any medications? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substances? _____

Does your occupation or your hobbies require an impact-resistant lens or safety frame and lenses? _____

CONTACT LENS INFORMATION

Do you wear contact lenses? No Yes

If yes: Soft Conventional
 Hard/Gas Permeable Disposable How often do you change lenses? _____

I sleep in my contacts How many days maximum? _____

I remove them before sleeping

VISION INSURANCE INFORMATION - IF APPLICABLE

Name of Vision Insurance Vision Service Plan / EyeMed / MES / Spectera / Davis / Other

Your Social Security # _____

Primary Member's Name _____ Primary Member's Birthdate _____

Relation to Member Self Spouse Dependent

Primary Member's Social Security # _____

I hereby authorize payment of my insurance benefits to Stein Optometric. I understand I am financially responsible for any charges, whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to Stein Optometric. I authorize Stein Optometric to release any information required to process any and all claims for reimbursement on my behalf. A copy of this authorization may be used in place of the original. PAYMENT OF INSURANCE DEDUCTIBLES DUE ON DATE OF SERVICE.

Signature _____ Date _____