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

☐ Glasses Exam / Routine Eye Examination
☐ Contact Lens Exam and Lenses
☐ Refractive Surgery (LASIK) Evaluation
Date of Last Eye Exam_____
☐ Retinal photo (for monitoring patients with high blood pressure, diabetes, glaucoma, macular degeneration, etc.)
*** Additional fees will apply.
☐ Other_____

MEDICAL AND EYE HISTORY

Do you have:			**Does anyone in your family have:**		
High blood pressure	☐ No	☐ Yes	High blood pressure	☐ No	☐ Yes, who?_____
Diabetes	☐ No	☐ Yes	Diabetes	☐ No	☐ Yes, who?_____
Heart Disease	☐ No	☐ Yes	Heart Disease	☐ No	☐ Yes, who?_____
High Cholesterol	☐ No	☐ Yes	High Cholesterol	☐ No	☐ Yes, who?_____
Cancer	☐ No	☐ Yes	Cancer	☐ No	☐ Yes, who?_____
Glaucoma	☐ No	☐ Yes	Glaucoma	☐ No	☐ Yes, who?_____
Cataracts	☐ No	☐ Yes	Cataracts	☐ No	☐ Yes, who?_____
Inherited Diseases	☐ No	☐ Yes	Inherited Diseases	☐ No	☐ Yes, who?_____
Allergies	☐ No	☐ 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 Center. 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 Center. I authorize Stein Optometric Center 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_____