

# WELCOME TO STEIN OPTOMETRIC CENTER

(must be updated at every visit)

<b>PATIENT INFORMATION</b>	<input type="checkbox"/> NEW PATIENT	<input type="checkbox"/> PREVIOUS PATIENT	TODAY'S DATE _____
Last Name _____	First Name _____	<input type="checkbox"/> Male	<input type="checkbox"/> 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

<b>Do you have:</b>		<b>Does anyone in your family have:</b>	
High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes	High blood pressure	<input type="checkbox"/> No <input type="checkbox"/> Yes, who? _____
Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes	Diabetes	<input type="checkbox"/> No <input type="checkbox"/> Yes, who? _____
Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart Disease	<input type="checkbox"/> No <input type="checkbox"/> Yes, who? _____
High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes	High Cholesterol	<input type="checkbox"/> No <input type="checkbox"/> Yes, who? _____
Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No <input type="checkbox"/> Yes, who? _____
Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes	Glaucoma	<input type="checkbox"/> No <input type="checkbox"/> Yes, who? _____
Cataracts	<input type="checkbox"/> No <input type="checkbox"/> Yes	Cataracts	<input type="checkbox"/> No <input type="checkbox"/> Yes, who? _____
Inherited Diseases	<input type="checkbox"/> No <input type="checkbox"/> Yes	Inherited Diseases	<input type="checkbox"/> No <input type="checkbox"/> Yes, who? _____
Allergies	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Any Other Health Problems _____	<input type="checkbox"/> self <input type="checkbox"/> family member _____		
Any Eye Problems/Surgeries _____	<input type="checkbox"/> self <input type="checkbox"/> family member _____		
Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Did you have <b>LASIK</b> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?	_____
List any <b>medications</b> you are taking _____			
<b>Allergies</b> 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?	<input type="checkbox"/> No <input type="checkbox"/> Yes
If yes:	<input type="checkbox"/> Soft <input type="checkbox"/> Conventional
	<input type="checkbox"/> Hard/Gas Permeable <input type="checkbox"/> Disposable
	How often do you change lenses? _____
<input type="checkbox"/> I sleep in my contacts	How many days maximum? _____
<input type="checkbox"/> I remove them before sleeping	

## VISION INSURANCE INFORMATION – IF APPLICABLE

Name of Vision Insurance	_____ <b>Vision Service Plan / EyeMed / MES / Spectera / Davis / Other</b> _____
Your Social Security #	_____
Primary Member's Name	_____ Primary Member's Birthdate _____
Relation to Member	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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 _____