

Downey Eyecare Center

PATIENT INFORMATION

 NEW PATIENT PREVIOUS PATIENT

TODAY'S DATE

Last Name _____ First Name _____ Male Female
Address _____ City _____ State _____ Zip _____
Birthdate _____ Age _____ Home Phone (____) _____ Work Phone (____) _____
Occupation _____ Employer _____

REASON FOR TODAY'S VISIT

Email

Glasses Exam Other _____
 Contact Lens Exam and Lenses
 Refractive Surgery Evaluation Date of Last Eye Exam _____

MEDICAL AND EYE HISTORY

Do you have:

High blood pressure No Yes
Diabetes No Yes
Heart Disease No Yes
Cancer No Yes
Glaucoma No Yes
Cataracts No Yes
Allergies No Yes
Inherited Diseases No Yes
Any Other Health Problems _____
Any Eye Problems/Surgeries _____
Are you pregnant? Yes No

Does anyone in your family have:

Yes, who _____
 Yes, who _____
 Yes, who _____
 Yes, who _____
 Yes, who _____
 Yes, who _____
 Yes, who _____
 Yes, who _____
 self family member _____
 self family member _____

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? Please specify _____

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 _____
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 _____