

**Welcome!** Please read and complete this form, and sign where indicated.

**Patient Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Sex:  Male  Female

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Payment Information**

Person Responsible for Payment: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_

**Medical & Union Insurance Information**

UNION or VISION Coverage:

Coverage: \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Primary MEDICAL Insurance:

Coverage: \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Amt of Co-Pay: \$ \_\_\_\_\_ Or Deductible: \$ \_\_\_\_\_

Additional MEDICAL Insurance:

Coverage: \_\_\_\_\_ ID#: \_\_\_\_\_

Address: \_\_\_\_\_

**Signature Authorization:** I authorize release of any medical or other information necessary to process this or future claims to HCFA or its agents. I also authorize payment of Medicare or other medical benefits to Dr. Mark Stadlen at American Eye Care. I authorize use of my signature on all insurance forms. I understand that I am responsible for payment of professional services and/or materials not covered by insurance or union benefits.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Medical History & Lifestyle Information**

Do you or a family member have any of the following conditions? If so, who? *(Check all that apply)*  
who?

- Diabetes \_\_\_\_\_
- Hypertension \_\_\_\_\_
- Thyroid \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Cataracts \_\_\_\_\_
- Glaucoma \_\_\_\_\_
- Macular Degeneration \_\_\_\_\_
- Blindness \_\_\_\_\_

Please check all that apply to you

- Headache
- Red Eyes
- Dry Eyes
- Crusty Lids
- Squinting
- Light Sensitive
- Floating Spots
- Flashes of Light
- Itchy Eyes
- Double Vision

Are you a smoker?  Yes  No  
 Do you use alcohol?  Yes  No  
 Have you ever had eye surgery?  Yes  No

When? \_\_\_\_\_ For what? \_\_\_\_\_

Please list your current medications:

\_\_\_\_\_  
 \_\_\_\_\_

Please check all that apply to you

- Computer User
  - Racquetball
  - Fishing
  - Skiing
  - Enjoy being out of doors
  - Interested in Lasik for: (circle one) me / someone else
  - Interested in Contact Lenses
  - Current or Previous Contact Lens Wearer
  - Sun Worshiper
  - Baseball
  - Boating
  - Sewing
  - Golfing
  - Tennis
  - Swimming
  - Reading
- My contacts are/were  Soft  Hard  Other