Dr. Robert Stahl & Dr. Amy Jo Calder Optometry
Patient Information Form

WELCOME TO OUR OFFICE!

Date_____/_____/_____

Last Name _____ First Name _____ MI _____ ❑Male ❑ Female

Social Security Number _____ Date of Birth _____/_____/_____ Age _____

Home Address _____

City _____ State _____ Zip _____

Primary Phone # (_____)_____(❑Home ❑Cell ❑Work) Secondary Ph# (_____)_____(❑Home ❑Cell ❑Work)

Other Phone # (_____)_____(❑Home ❑Cell ❑Work) E-mail Address _____

Employer _____ Occupation _____

Name of Spouse (Parent/guardian if a minor) _____

Emergency Contact _____ Phone # (_____)_____ Relationship _____

Are you a new patient? ❑YES ❑ NO If yes, how were you referred to us? _____

Do you have VISION insurance? ❑YES ❑NO If yes, which one? _____

Do you have MEDICAL insurance? ❑YES ❑NO If yes, which one? _____

PERSONAL EYE HISTORY

Date of last eye examination ___/___/___ Name of last Optometrist / Ophthalmologist _____

Reason for Today's Visit? _____ Is this a Routine Annual Exam? ❑Yes ❑No

Decreased vision (❑dist/❑near) Other Ocular Problems you are having_____

Have you had eye surgeries or eye injuries in the past? ❑YES ❑ NO If yes, explain _____

Do you wear glasses?	❑YES ❑NO	Do you have back-up glasses?	❑YES ❑NO
Would you benefit from thinner, lighter lenses?	❑YES ❑NO	Do you have problems with glare/reflections?	❑YES ❑NO
Do you have sensitivity to bright lights?	❑YES ❑NO	Do you spend a lot of time outdoors?	❑YES ❑NO
Do you have a pair of sunglasses?	❑YES ❑NO	Do you work on the computer for long periods?	❑YES ❑NO
Do you have computer vision problems?	❑YES ❑NO	Do you have computer glasses?	❑YES ❑NO

Do you wear contact lenses? ❑YES ❑NO If yes, what type?_____
Are you interested in trying contact lenses? ❑YES ❑NO
Do you have glaucoma? ❑YES ❑NO
Do you have any other eye conditions/problems? ❑YES ❑NO If yes, please describe _____
Are you interested in LASIK or refractive surgery ❑YES ❑NO

List the sports you participate in: _____ _____ _____

List the hobbies you participate in: _____ _____ _____

Please turn over form and complete the second page

MEDICAL INFORMATION

Date of last medical examination _____/_____/_____ Name of Medical Doctor: _____

List any medications you take (including oral contraceptives, aspirin and over the counter meds)

_____

_____

Do you have any allergies? ❑YES ❑NO If yes, explain _____

Do you have any allergies to medication? ❑YES ❑NO If yes, explain _____

List all major injuries, surgeries and/or hospitalizations you have had _____

Are you nursing or pregnant? ❑YES ❑NO

REVIEW OF SYMPTOMS

Do you currently of have you ever had any problems in the following areas?

Gastrointestinal	**❑YES ❑NO**	**Musculoskeletal**	**❑YES ❑NO**
Ears/Nose/Throat	**❑YES ❑NO**	**Diabetes**	**❑YES ❑NO**
Cardiovascular	**❑YES ❑NO**	**Mental**	**❑YES ❑NO**
Respiratory	**❑YES ❑NO**	**Endocrine (glands)**	**❑YES ❑NO**
Eyes	**❑YES ❑NO**	**Blood / Lymph**	**❑YES ❑NO**
Neurological	**❑YES ❑NO**	**Allergic / Immunologic**	**❑YES ❑NO**
Genitourinary	**❑YES ❑NO**	**Skin**	**❑YES ❑NO**

Other Medical Problem_____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased)

Blindness	**❑YES ❑NO**	**Diabetes**	**❑YES ❑NO**	**Cataracts**	**❑YES ❑NO**
Heart Disease	**❑YES ❑NO**	**Crossed Eyes**	**❑YES ❑NO**	**High Blood Pressure**	**❑YES ❑NO**
Macular Degeneration	**❑YES ❑NO**	**Kidney Disease**	**❑YES ❑NO**	**Retinal Detachment**	**❑YES ❑NO**
Lupus	**❑YES ❑NO**	**Retinal Disease**	**❑YES ❑NO**	**Thyroid Disease**	**❑YES ❑NO**
Arthritis	**❑YES ❑NO**	**Cancer**	**❑YES ❑NO**		

Other (please list/explain) _____

Do you use tobacco products? ❑YES ❑NO Alcohol? ❑YES ❑NO Other drugs/substances? ❑YES ❑NO

Have you ever been exposed to or infected with:

HIV ❑YES ❑NO Hepatitis ❑YES ❑NO Gonorrhea ❑YES ❑NO Syphilis ❑YES ❑NO

If yes, please explain _____

I, the undersigned, have insurance coverage with the carrier listed on the 1st page of this questionnaire and assign directly to Drs. Robert J. Stahl & Amy J. Calder, OD's, APC (from here on referred to as "Drs. S & C"), all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. I request that payment of all authorized insurance/Medicare benefits be paid to Drs. S & C for any services furnished me by Drs. S & C or their agents. If Medicare is my health insurance, I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the releasing of the information to the insurer or the agency shown. In Medicare assigned cases, the physician or supplier of services agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services, such as a refraction. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient Signature _____ Date _____ / _____ / _____

Doctor's Review Initials _____Date ____/_____/_____