

THE EYE CARE CENTER OF STAMFORD, LLC  
1275 SUMMER STREET  
STAMFORD, CT 06905

Welcome!

Patient Registration Information

Date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex  F  M Marital Status  Married  Single  Divorced  Widowed

Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

Business Address \_\_\_\_\_ Occupation \_\_\_\_\_

Whom should we thank for referring you? \_\_\_\_\_ Primary Physician \_\_\_\_\_

In case of emergency whom should we contact? \_\_\_\_\_ Phone \_\_\_\_\_

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Person Responsible for Account \_\_\_\_\_  
Last Name First Name

Relationship to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Primary Insurance Co. Name \_\_\_\_\_

Group Number \_\_\_\_\_ I.D. Number \_\_\_\_\_

Secondary Insurance (if applicable) \_\_\_\_\_

Group Number \_\_\_\_\_ I.D. Number \_\_\_\_\_

I hereby authorized the release of any medical information to my Insurance, necessary to process claims. I request payment from Medicare and/or my insurance to Eric Wasserman, M.D. I understand that payment is due in full at time of service unless prior arrangements have been made. Should it become necessary to send my account to a Collection Agency, I will additionally be responsible for all associated fees.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Are you here to have your eyes checked for glasses? Yes No

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**PATIENT INFORMATION**

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

Date of Birth: \_\_\_\_\_

List all allergies to medications: \_\_\_\_\_

Purpose of your visit: \_\_\_\_\_

**Medical History** (Circle the appropriate answer):

If you answer yes to any of the following questions, a technician will ask you for details.

- |   |     |    |
|---|-----|----|
| 1. Do you have glaucoma?                                  | Yes | No |
| 2. Do you have cataracts?                                 | Yes | No |
| 3. Have you ever had surgery?                             | Yes | No |
| 4. Have you ever had an eye injury?                       | Yes | No |
| 5. Have you ever had a temporary loss of vision?          | Yes | No |
| 6. Have you ever had a lazy eye?                          | Yes | No |
| 7. Do you have sleep apnea?                               | Yes | No |
| 8. Do you have diabetes?                                  | Yes | No |
| 9. Have you ever been diagnosed with high blood pressure? | Yes | No |
| 10. Do you have heart trouble?                            | Yes | No |
| 11. Have you ever been diagnosed with lung problems?      | Yes | No |
| 12. Have you ever had a stroke?                           | Yes | No |
| 13. Have you ever had stomach or intestinal problems?     | Yes | No |
| 14. Have ever had urinary tract problems?                 | Yes | No |
| 15. Have ever been diagnosed with cancer?                 | Yes | No |
| 16. Have ever been diagnosed with thyroid disease?        | Yes | No |
| 17. Do you have bleeding problems?                        | Yes | No |
| 18. Do you have arthritis?                                | Yes | No |
| 19. Have you ever been hospitalized?                      | Yes | No |

List previous surgeries and dates:

\_\_\_\_\_

- |                                  |     |    |
|----------------------------------|-----|----|
| 20. Have you ever used IV drugs? | Yes | No |
|----------------------------------|-----|----|

List any other illnesses or conditions you are being followed or treated for: \_\_\_\_\_

\_\_\_\_\_

List all current medications and dosages: \_\_\_\_\_

\_\_\_\_\_

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**FAMILY HISTORY**

Do you have a family history of any of the following?

- |                          |     |    |
|--------------------------|-----|----|
| 1. Diabetes              | Yes | No |
| 2. Retinal Detachment?   | Yes | No |
| 3. Glaucoma              | Yes | No |
| 4. Macular Degeneration? | Yes | No |
| 5. Other? _____          |     |    |

**VISUAL HISTORY**

- |   |     |    |
|---|-----|----|
| 1. Do you have more than one pair of prescription eyewear?    | Yes | No |
| 2. Do you wear bifocals?                                      | Yes | No |
| If so, are you bothered by head tilting or restricted vision? | Yes | No |
| 3. Do you use the computer more than 1 – 2 hours per day?     | Yes | No |
| 4. Are you bothered by reflections, particularly at night?    | Yes | No |
| 5. Are your current eyeglasses uncomfortable?                 | Yes | No |
| 6. Are you interested in wearing contact lenses?              | Yes | No |

What is your current occupation? \_\_\_\_\_

Do you smoke? How many packs per day? \_\_\_\_\_

If you ever smoked, how many packs per day and when you stopped \_\_\_\_\_

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Have you traveled out of the country in the last six months? If yes, where? \_\_\_\_\_

Patient Signature: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

Physician Signature: \_\_\_\_\_

Technician Signature: \_\_\_\_\_

Date: \_\_\_\_\_