Dr. Kenneth Wiener & Dr. Steven Kas

Optometrists

WELCOME!

PERSONAL INFORMATION

Name: ____ Sex: ☐M ☐F Date of Birth: ____ /____/______ Age: _____
(LAST) (FIRST)

Address: ____
Street City State Zip

Home Phone: (_____)______________ Work Phone: (_____)_____________ Social Security #: _____-____-______

Employer: ________________________ Occupation: ____________________ E-Mail: ___________________________
Recall Purpose Only

INSURANCES

VISION INSURANCE:

Circle all that apply: VSP, MES, EyeMed, Spectera, Delta, EyeMed, Safeguard, Healthy Families, Others: _____________

Member Name: ________________________ DOB: ____/____/_____ SS#: _______________ Relationship to Pt: ________

MEDICAL INSURANCE: *(All medically related eye visits are billed to your **Medical** Insurance)*
Circle all that apply: Blue Cross/Shields, Medi-Care, Medi-Cal, Pacific Care, Cigna, Aetna, United Health, Others: _____

Member Name: ________________________ DOB: ____/____/_____ SS#: _______________ Relationship to Pt: ________

WHAT IS THE REASON FOR TODAY'S VISIT? (Check all that apply)

☐ I have an **Eye Disease or Eye Problem** requiring examination: ____

☐ I want **Glasses:** Age of present glasses: _______

☐ I want **Contact Lenses:** ☐Clear ☐Colored Brand? _____________ Solution?________________
Would you like to **sleep** in your Contact Lenses? ☐Y ☐N
First time trying contact lenses? ☐Y ☐N

☐ I am interested in ***Lasik*** **Refractive Surgery:**
How soon? (Circle One) 1mo. 3mo. 6mo. 1yr. Undecided

DO YOU EXPERIENCE ANY OF THE FOLLOWING? (Check all that apply)

☐ Distance vision blurred w/ glasses	☐ Dry/ Burning eyes	☐ See flashing lights
☐ Near vision blurred w/ glasses	☐ Watery eyes	☐ See floaters or spots
☐ Headaches related to eyes	☐ Itchy eyes	☐ Double Vision
☐ Eye strain	☐ Red eyes	☐ Sensitivity to lights

MEDICAL AND EYE HISTORY (Check all that apply to you or your immediate family)

Last Eye Exam _______ **Where?** ________________ **Last Physical Exam** _______ **Where?** _______________

	Self	Family		Self	Family		Self	Family
Diabetes	☐	☐	Asthma	☐	☐	Glaucoma	☐	☐
High Blood Pressure	☐	☐	Thyroid Problems	☐	☐	Cataracts	☐	☐
Heart Condition	☐	☐	Sinus Problems	☐	☐	Lazy/Cross Eye	☐	☐
Cholesterol Problems	☐	☐	Cancer	☐	☐	Retinal Disease	☐	☐

Are you pregnant? (if applicable) ☐Y ☐N
Are you currently taking any medication? ☐Y ☐N If yes, please list: ____________________________________
Are you allergic to any medication? ☐Y ☐N If yes, please list: ____________________________________
Have you had any eye surgery or injury? ☐Y ☐N If yes, please explain: __________________________________

Who may we thank for kindly referring you to our office? ______________________________

____ ____________________
PATIENT SIGNATURE (If under 18, parent signature required) DATE

THANK YOU!