Welcome to
Douglas L. Stephenson, O.D., P.A.

PATIENT ENTRANCE INFORMATION		
Preferred Contact Method ❑ Mail ❑ Phone ❑ Text ❑ Email		
Cell Phone:	**Home Phone:**	**Work Phone:**
Email:		
Would you like to be set up on our patient portal? ❑ Yes ❑ No		

SOCIAL HISTORY	
Please list Hobbies/Recreational Sports you enjoy:	
Do you use tobacco? ❑ Yes ❑ No	**Do you drink alcohol?** ❑ Yes ❑ No

MY INFORMATION BELOW IS THE SAME AS MY LAST VISIT. ❑ **YES** (Please print your name, sign the bottom and continue to back)

DEMOGRAPHIC INFORMATION		
Full Legal Name:		
Street Address:		
City, State, Zip:		
Patient Social Security Number:		
Date of Birth:	Sex: ❑ Male ❑ Female	
Occupation:	Employer name/address:	
Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed		
Emergency Contact Name/Phone #:	Whom may we thank for referring you?	

INSURANCE INFORMATION

	Vision Plan	Medicare	Supplemental/Secondary
Insurance Company			
Policyholder's Name			
Identification #			
Policyholder's Date of Birth			
Policyholder's SS#			
Relationship to Policyholder			

ASSIGNMENT AND RELEASE/FINANCIAL RESPONSIBILITY

I certify that I, and/or my dependent(s), have insurance coverage with the aforementioned insurance and assign directly to Douglas L. Stephenson, OD, PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all co-pays and/or coinsurance. I also understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature: _____ Relationship to Insured: _____ Date: _____

PLEASE CONTINUE TO BACK

EYE HEALTH HISTORY

Date of Last Eye Exam:	Eye Care Physician's Name:

Do you currently wear glasses? ❑ Yes ❑ No

❑ Full time ❑ Part time ❑ Readers ❑ Distance ❑ Progressive/Bifocals ❑ Computer

Do you currently wear contacts? ❑ Yes ❑ No Type: How Many Hours a Day:

Have you or a family member experienced, or been treated for, any of the following? Check all that apply and please specify family member.

Cataracts	❑ Self	❑ Family:	Lazy Eye (Amblyopia)	❑ Self	❑ Family:
Crossed Eyes	❑ Self	❑ Family:	Macular Degeneration	❑ Self	❑ Family:
Glaucoma	❑ Self	❑ Family:	Retinal Detachment	❑ Self	❑ Family:
Eye Surgery	❑ Self	❑ Family:			

Are you currently experiencing, or have you experienced, any of the following? Check all that apply.

❑ Blurry Vision Near	❑ Double Vision	❑ Floaters or Spots	❑ Light Sensitivity
❑ Blurry Vision Distance	❑ Dryness	❑ Halos/Starbursts/Glare	❑ Poor Color Vision
❑ Burning	❑ Excess Tearing / Watering	❑ Headaches	❑ Redness
❑ Decreased Night Vision	❑ Eye Infection	❑ Itching	❑ Sandy or Gritty Feeling
❑ Discharge	❑ Eye Pain or Soreness	❑ Light Flashes	❑ Other (explain)

MEDICAL HISTORY

Please indicate if you or a blood relative have, or have ever had, any of the following problems or conditions?

	Yourself		Family			Yourself		Family	
	Yes	No	Yes	No		Yes	No	Yes	No
Acid Reflux/Ulcer	❑	❑	❑	❑	Hearing Loss	❑	❑	❑	❑
AIDS/HIV	❑	❑	❑	❑	Heart Disease	❑	❑	❑	❑
Attention Deficit Disorder	❑	❑	❑	❑	High Blood Pressure	❑	❑	❑	❑
Anxiety Disorder	❑	❑	❑	❑	Herpes Simplex (Cold sores)	❑	❑	❑	❑
Arthritis	❑	❑	❑	❑	Herpes Zoster (Shingles)	❑	❑	❑	❑
Asthma	❑	❑	❑	❑	High Cholesterol	❑	❑	❑	❑
Autism Spectrum Disorder	❑	❑	❑	❑	Hormonal Dysfunction	❑	❑	❑	❑
Bipolar Disorder	❑	❑	❑	❑	Kidney Disease	❑	❑	❑	❑
Blood/Lymph Disorder	❑	❑	❑	❑	Lupus	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	Migraines	❑	❑	❑	❑
Cerebral Palsy	❑	❑	❑	❑	Multiple Sclerosis	❑	❑	❑	❑
Chronic Obstruct. Pulmonary Disease (COPD)	❑	❑	❑	❑	Muscular Dystrophy	❑	❑	❑	❑
Colitis	❑	❑	❑	❑	Neurological Conditions	❑	❑	❑	❑
Congestive Heart Failure	❑	❑	❑	❑	Osteoporosis	❑	❑	❑	❑
Crohn's Disease	❑	❑	❑	❑	Prostate disease	❑	❑	❑	❑
Depression	❑	❑	❑	❑	Psychiatric Disorder	❑	❑	❑	❑
Developmental Disorders	❑	❑	❑	❑	Psoriasis	❑	❑	❑	❑
Diabetes (please indicate Type 1 or Type 2)	❑	❑	❑	❑	Rheumatoid Arthritis	❑	❑	❑	❑
Drug Sensitivity	❑	❑	❑	❑	Rosacea	❑	❑	❑	❑
Dry Mouth	❑	❑	❑	❑	Seizures	❑	❑	❑	❑
Ear, Nose, Throat Conditions	❑	❑	❑	❑	Sjogren's Syndrome	❑	❑	❑	❑
Emphysema	❑	❑	❑	❑	Sleep Apnea	❑	❑	❑	❑
Epilepsy	❑	❑	❑	❑	STD (Herpetic/Chlamydia)	❑	❑	❑	❑
Eczema	❑	❑	❑	❑	Stroke/TIA	❑	❑	❑	❑
Fibromyalgia	❑	❑	❑	❑	Thyroid Dysfunction	❑	❑	❑	❑
Gastrointestinal Conditions	❑	❑	❑	❑	Vascular Disease	❑	❑	❑	❑
Gout	❑	❑	❑	❑		❑	❑	❑	❑
Are you currently pregnant or nursing?	❑ Yes ❑ No								
Please list any previous surgeries with dates:									

MEDICATIONS/ALLERGIES

Current Medications

Please list all medications, including over the counter and supplements.

Allergies

Please list all allergies, drug and environmental.