Stahl Eye Associates 450 Enda Blvd Garden City, NY 11530 516-832-8000

WELCOME! Please complete this form and return it to the receptionist so we may prepare your chart.

Personal Information				
Last name: SHREE	**First Name:** LAXMAN	**M.I.**		**DOB:**
SS#:	**Bill to same name Y N**	**Sex: M.F**	**Age:**	**Today's date:**
Street Address:				
City:		**State :**	**Zip**	
e-mail address to receive our newsletter:		**Home Phone:**		
Employer:				
Occupation:		**Employer Phone:**		
Name Of Nearest Relative:		**Phone:**		

Whom may we thank for referring you to us (Name and address):	
Insurance Information	
Medicare #:	**Medicaid #:**
Is Medicare your secondary payor as a result of TEFRA ? Y N	**Are you currently a member of an HMO, HIP or other managed care plan? Y N**
Primary Insurance	
Private Insurance Name: GEICO	**Insured's Name:** **LAXMAN, SHREE**
Insured's date of birth: / **Insured's SS #**	**Relationship to Insured:** **Self Spouse Child Other**
ID #:	**Group:**
Secondary Insurance	
Private Insurance Name: GEICO	**Insured's Name** SHREE

Insured's date of birth: Insured's SS # Relationship to Insured:

Self Spouse Child Other

ID # Group:

I request that payment of authorized benefits be made directly to Stahl Eye Associates on my behalf for services furnished to me by the physician. I authorize any holder of medical information about me to release to the Health Care Financing

Administration and/or agent any information needed to determine these benefits or the benefits payable for related services.

Signature : X Date :

Please turn over and fill out the other side of this form

Medical History

Diabetes N Y for ____ years; Last blood sugar: Taken when? _____

Last Hemoglobin A1C Taken when? _____

Asthma N Y for ____ years; Well controlled on medication? N Y

High Blood Pressure N Y for ____ years; Well controlled on medication? N Y

Glaucoma N Y for ____ years; Well controlled on medication? N Y

Heart Attack N Y Number of attacks: ____ what year was the last one :_____

Stroke N Y Number of strokes: what year was the last one : _____

High Cholesterol Arthritis N Y

Heart Disease Cancer N Y Of what?_____

Bronchitis Emphysema N Y

Other (Please list :

Medication

List any medications you are allergic to :

Eye Medications you are taking :

Other medication that you are taking:

Eye History

How many years ago was your last eye examination:	**Have you ever had any surgery performed on your eyes? N Y**

Do you wear glasses ? N Y if yes, for Distance Reading Only Bifocals Progressive Bifocals Glasses are years old

Do you wear contact lenses? N Y if yes: Hard Soft Wearing for years

What is the main problem that you are having with your eyes that you are here for today:

Primary Care Physician/Family Doctor

Name:
Address
Do you want us to send a letter of your finding to this doctor? Y N