STARBASE
OPTOMETRY P.C

DR. SEAN C. FEIN || DR. LARA MENDELSSOHN || DR. RICKY GURPRASAD

PATIENT INFORMATION

MR / MS / MRS LAST NAME _____ FIRST NAME _____ DOB ___/___/_____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

CELL PHONE ( ) _____ WORK PHONE ( ) _____

EMAIL ADDRESS _____ @ _____.COM SIGNATURE _____

OCCUPATION _____ EMPLOYER _____

FAVORITE SPORTS/HOBBIES THAT REQUIRE CONTACT LENSES OR GLASSES: _____

Please **circle** your corresponding insurances
MEDICAL: AETNA / BCBS / UNITED HEALTHCARE / OXFORD FREEDOM
VISION: VSP / EYEMED / AETNA VISION / BLUEVIEW / HUMANA VCP

Are you: ☐ SINGLE ☐ MARRIED ☐ OTHER/ SPECIFY:_____

Name of primary insured: _____ Relation: _____ Date of Birth:___/ ___/ _____

How would you like to be reminded of your annual eye exam next year?
□ EMAIL □ PHONE

OCULAR (EYE) & MEDICAL HISTORY

DATE OF LAST EYE EXAM ____/____/_____ FROM DR. _____
HAVE YOU EVER HAD YOUR EYES DILATED? □ YES □ NO **HAVE YOU EVER HAD RETINAL PHOTOS?** □ YES □ NO
HAVE YOU HAD ANY EYE SURGERY (INCLUDING LASIK) OR AN EYE INJURY? □ YES □ NO
DO YOU HAVE FREQUENT HEADACHES? □ YES □ NO
ARE YOU PREGNANT OR NURSING? □ YES □ NO

DO YOU OR ANY BLOOD RELATIVES (PARENTS, GRANDPARENTS, SIBLINGS) HAVE:

	SELF	RELATIVE	NONE		SELF	RELATIVE	NONE
HIGH BLOOD PRESSURE	☐	☐	☐	**ASTHMA**	☐	☐	☐
DIABETES	☐	☐	☐	**SEASONAL ALLERGIES**	☐	☐	☐
HEART DISEASE	☐	☐	☐				
GLAUCOMA	☐	☐	☐	**RETINAL DISEASE**	☐	☐	☐
MACULAR DEGENERATION	☐	☐	☐	**EYE CANCER**	☐	☐	☐

ARE YOU TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATION, INCLUDING EYEDROPS? PLEASE LIST:

_____

DO YOU HAVE ANY KNOWN ALLERGIES TO MEDICATIONS OR CONTACT LENS SOLUTIONS? PLEASE LIST:

_____

WHAT IS THE NAME & LOCATION OF YOUR PREFERRED PHARMACY IN CASE WE NEED TO PRESCRIBE MEDICATION TODAY?

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