(888) 557-4448 I stahlny.com I Garden City I Manhattan I Hauppauge
Marc Werner, M.D. I Thierry Hufnagel, M.D. I Benjamin Chang, M.D.

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

PATIENT INFORMATION

Last Name:	First Name:		MI:	DOB:
SS#:	Bill to same name: Y N	Sex: M F	Age:	Date:
Street Address:				
City:			State:	Zip:
Email 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 & Address):				

RACE, ETHNICITY AND PREFERRED LANGUAGE

Race: ❑ American Indian ❑ Asian ❑ Black ❑ Native Hawaiian ❑ Type-Unkown ❑ White

Ethnicity: ❑ Hispanic ❑ Non-Hispanic ❑ Type-Unkown	Preferred Language:

INSURANCE INFORMATION

Medicare #:	Medicaid #:

Is Medicare your secondary payer 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:		Insured's Name:
Insured's DOB:	Insured's SS#:	Relationship: Self Spouse Child Other
ID#:		Group:

SECONDARY INSURANCE

Private Insurance Name:		Insured's Name:
Insured's DOB:	Insured's SS#:	Relationship: Self Spouse Child Other
ID#:		Group:

PAYMENT OF BENEFITS DIRECTLY TO THE PHYSICIAN

I request that payment of authorized benefits be made directly to Stahl Eyecare Experts 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:	Date:

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

PATIENT MEDICAL INFORMATION

Diabetes	N Y		Last Blood Sugar: Last Hemoglobin AIC:	Taken When?: Taken When?:	
Asthma	N Y	For ______ Years	Well controlled on medication?	N Y	
High Blood Pres-sure	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	# of attacks: _____	What year was the last one?		
Stroke	N Y	# of stokes: ______	What year was the last one?		
High Cholesterol	N Y		Arthritis	N Y	
Heart Disease	N Y		Cancer	N Y	Type:
Bronchitis	N Y		Emphysema	N Y	
Smoking	❑ Current Every Day Smoker ❑ Current Some Day Smoker ❑ Never Smoker ❑ Former Smoker ❑ Unkown If Ever Smokeed				
Other (Please list):					

MEDICATIONS

List any medications you are allergic to:

Eye medications you are taking:

Other medications that you are taking:

EYE HISTORY

When was your last eye examination?	Have you had any surgery performed on your eyes? N Y If yes, for ______________________________

Do you wear glasses? N Y

Glasses are ______ years old.

If yes, for Distance Reading Only Bifocals Progressive Bifocals

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?

I AM INTERESTED IN THE FOLLOWING

❑ ***LASIK (Laser Vision Correction)*** ❑ ***Botox® Cosmetic*** ❑ ***Other Cosmetic Procedures***

PRIMARY CARE PHYSICIAN/FAMILY DOCTOR

Name:

Address:

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