

**NORWALK EYE CARE
DR. MARK S. FEDER
DR. JENNIFER L. STEWART
5 Eversley Avenue
Norwalk, CT 06851
(203) 853-1010**

Patient Name:

Appointment Date:

Appointment Time:

Enclosed are the two forms you need to bring with you at the time of your appointment. Please fill them out in advance.

We would appreciate it if you would also bring to your appointment the following:

- All current glasses and sunglasses
- Contact lenses or information regarding your contact lens prescription. (if applicable)
- A list of all medications including vitamins and any other supplements you are taking.
- Your insurance card or cards.

We thank you for scheduling an appointment with our office and look forward to seeing you soon.

DR. MARK S. FEDER
PHONE (203)853-1010

NORWALK EYECARE
5 Eversley Avenue Norwalk, CT 06851

DR. JENNIFER L. STEWART
FAX (203)866-0767

PATIENT REGISTRATION FORM
PERSONAL INFORMATION

Patient's Name (Mr. Mrs. Ms. Miss) _____ DOB ___/___/___ Date _____

Address _____

Referred By _____

City _____ State _____ Zip _____

Home Phone # _____

Social Security # _____

Business Phone # _____

Email Address _____

Cell Phone # _____

Occupation _____ Employed By _____

Hobbies _____

Family Physician Name: _____

Emergency Contact _____ PH: _____

Address: _____ PH: _____

Relationship to patient _____

INSURANCE INFORMATION

Primary Insurance _____

Co-Insurance _____

Policy holder's name _____ DOB ___/___/___

Policy holder's name _____ DOB ___/___/___

Relationship to patient _____

Relationship to patient _____

ID# _____ Group# _____

ID# _____ Group# _____

MEDICAL HISTORY

What is the main problem you are having with your EYES or your GLASSES/CONTACT LENSES at the present time?

Please CIRCLE all MEDICAL PROBLEMS OR PRESENT ILLNESS that apply: (Diabetes, Heart disease, High blood pressure, Glaucoma, Blood disorders) List any other: _____

Please list ANY MEDICATION(S) you are currently taking:

Please CIRCLE ANY DISEASE in your family that apply: (Diabetes, Heart disease, High blood pressure, Blood disorders) List any other: _____

Has anyone in your family ever been (PLEASE CIRCLE) blind, had Glaucoma, Crossed eyes, Retinal disease or Lazy eye? Please list any other _____

Please state ANY MEDICATIONS you are ALLERGIC to: _____

Please CIRCLE: Are you CURRENTLY, have you PREVIOUSLY or have you NEVER worn contact lenses? If CURRENT please list what type and how long you have worn them _____

Have you ever had (PLEASE CIRCLE) an EYE INJURY, EYE INFECTION OR EYE SURGERY?

Have your eyes ever been (PLEASE CIRCLE) CROSSED OR TURNED OUT?

Statement: I agree to pay for all services rendered that are not covered by insurance.

Patient (parent or guardian) Signature: _____

Norwalk Eye Care
5 Eversley Avenue Suite 104
Norwalk, CT 06851

Welcome to our office. Please take a moment to answer these questions about your eyewear needs.

Name: _____ Date: _____

- | | | | |
|--|---|---|--------------------|
| 1. Are you having trouble seeing at night? | Y | N | |
| 2. Does detailed work and small print strain your eyes? | Y | N | |
| 3. Are you satisfied with your current sunglasses? | Y | N | |
| 4. Do you participate in any sports or have any hobbies? | Y | N | |
| 5. Are you planning on getting new glasses today? | Y | N | Only if RX changes |
| 6. Are you interested in trying contact lenses today? | Y | N | |

Email Address: _____

Please be aware we will keep this information confidential.