

Spring Klein Texas State Optical
Established Patient Form

Date: _____ Appointment Time: _____ Walk In Time: _____

Mr. Dr. _____
 Mrs. Ms. _____ Parent/Guardian: _____
 Last Name First Name Middle Initial

Address: _____ City _____ State _____ Zip Code _____

Date of Birth _____ Age _____ Social Security # _____

Occupation / Grade _____ E-Mail _____

Home Phone (____) ____ - ____ Cell Phone (____) ____ - ____ Business Phone (____) ____ - ____

Purpose for Today's Visit? _____

Are You Currently Wearing Contact Lenses or Interested in Being Fit in Them? ____ Yes ____ No

Are You Interested in Being Fitted for Contact Lenses Today? ____ Yes ____ No If Yes, What Type? _____

Other Family Members Who Are Patients of Ours: _____

GENERAL HEALTH				EYE HISTORY				CURRENT VISION PROBLEMS		
	YES	NO	IN FAMILY		YES	NO	IN FAMILY		YES	NO
Diabetes				Glaucoma				Blurry Vision at Distance		
Hypertension				Cataract				Blurry Vision Close-Up		
Heart Problems				"Lazy Eye"				"Halos" Around Lights		
Kidney Problems				Eye Injury				Poor Night Vision		
Thyroid Problems				Eye Surgery				Poor Color Vision		
Arthritis				Eye Infection				Flashes of Light		
Seasonal Allergies				Retinal Disease				Dry Eye		
High Cholesterol				Detached Retina				Seeing Double		
Cancer				Macular Degen.				Floaters or spots		
Other Problems:				Other:				Frequent Headaches		
								Watering Eyes		

List _____ **Known** _____ **Allergies:** _____

Medications Currently Being Taken & For What Conditions: _____

IF THE INSURANCE HAS CHANGED FROM YOUR LAST VISIT, PLEASE COMPLETE THE FOLLOWING:

Type of Insurance: (Please Circle) BCBS VSP EyeMed Spectera Superior Vision Humana Vision (VCP)
 Other: _____

Primary Member (If someone other than self): _____
 Last Name First Name Middle Initial

Primary Insured Social Security #: _____ Primary Insured Date of Birth: _____

For our contact lens patients, the fitting fee includes trials along with 2 follow up visits within 60 days. Any follow up there after will incur a fee of \$35/follow up during the 60 days. After 60 days, a new fit fee will be administered.
 If the contact lens fitting is not performed on the same day as the exam, you have 60 days to have a fit only performed; after 60 days a new comprehensive exam and fitting fee will be administered.
 If unable to adapt into new lenses, we will gladly re-check the prescription at no charge for a limited period. For single vision lenses, up to one week after receiving glasses and for multifocal lenses up to three weeks. After this period, patients will be charged \$35 for a recheck fee.
 If we are unable to satisfy your needs, you may request a refund within 14 days of receiving the glasses or contacts. Opened contact lens boxes cannot be refunded. All items approved for a refund will incur a restocking fee of upto 25% of purchase price. Requests may take upto 72 hours for approval from the Optical Lab.

By signing this form, you hereby agree to be financially responsible for any and all charges incurred by you that your insurance does not cover in full.
