Stone Oak Ophthalmology Center
Lifelong Comprehensive Eye Care

Kristin Story Held, M.D.
325 E. SONTERRA BLVD., SUITE 100 SAN ANTONIO, TX 78258

Patient Account Number
(For Office Use Only)
_____

Welcome to our office and thank you for selecting our healthcare team! To assist us in serving you, please fill out the confidential forms.

PATIENT INFORMATION (PLEASE PRINT)

FIRST NAME: _____ **INITIAL:** _____ **LAST NAME:** _____

ADDRESS: _____
Street/Apt # City State Zip

HOME PHONE: (_____)_____ **WORK PHONE:** (_____)_____ EXT:_____ **CELL:** (_____)_____

EMAIL: _____

DATE OF BIRTH: _____ **AGE**: _____ **SEX**: ☐ MALE ☐ FEMALE **MARITAL STATUS:** ☐ S ☐ M ☐ D ☐ W

OCCUPATION: _____

How did you hear about our office?

☐ Yellow Pages ☐ Friend ☐ Family Member ☐ Magazine ☐ Internet Search ☐ Website ☐ Other: _____

Another patient, who? _____ Another doctor, who? _____

PARENT/GUARDIAN/RESPONSIBLE PARTY INFORMATION (PLEASE PRINT)

FULL NAME: _____ RELATIONSHIP _____ PHONE: (_____)_____

ADDRESS: _____

EMERGENCY CONTACT INFORMATION (PLEASE PRINT)

FULL NAME: _____ **RELATIONSHIP** _____ **PHONE** (_____)_____

Patient's or Authorized Person's Signature

I agree to be responsible for payment of all services rendered on my behalf or my dependents. Payment is expected in full each visit.

_____ DATE: _____
SIGNATURE (PATIENT, GUARDIAN, OR PARENT OF MINOR)