

Patient Information
<p>Today's Date _____</p> <p>Last _____</p> <p>First _____ MI _____</p> <p>Street _____</p> <p>City _____ State _____</p> <p>Zip Code _____</p> <p>Home Phone _____</p> <p>Work Phone _____</p> <p>Patient's SSN _____</p> <p>Employer (or School) _____</p> <p>Occupation (or Grade) _____</p> <p>Spouse (or Parent's Name) _____</p> <p>Spouse (or Parent's Work) _____</p> <p>Date of Birth _____ Age _____</p> <p>Sex M F</p> <p>Email Address _____</p> <p>What is the major purpose of this visit? _____</p> <p>Any problems with your current contact lenses or glasses? _____</p> <p>VERY IMPORTANT! NEW PATIENTS ONLY: Who may we thank for referring you to our office? Name of friend or relative _____</p> <p>If not referred, how did you choose our office?</p> <p><input type="checkbox"/> Another Dr.</p> <p><input type="checkbox"/> Insurance List</p> <p><input type="checkbox"/> Saw Sign/Building</p> <p><input type="checkbox"/> Newspaper/Radio/TV</p> <p><input type="checkbox"/> Yellow Pages: Which directory? _____</p> <p><input type="checkbox"/> Web Page: Which Web Site? _____</p> <p><input type="checkbox"/> Other _____</p>

We are glad you have chosen our office for all of your eye care needs.

The mission of the doctors and staff of Windmill Eye Associates is to enhance our patient's quality of life by providing exceptional service through education and personal attention. Everything we do shall communicate this mission.

Insurance Information
<p><i>Please note that some insurance plans do NOT cover the Contact Lens Follow-Up Evaluation.</i></p> <p>Vision Insurance _____</p> <p>Subscriber Name _____</p> <p>Subscriber SSN _____</p> <p>Subscriber Birth Date _____</p> <p>Primary Medical Insurance _____</p> <p>Subscriber Name _____</p> <p>Subscriber SSN _____</p> <p>Subscriber Birth Date _____</p> <p>Do you participate in a flex spending account? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How will you settle your account today? <input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Credit Card</p>

Lifestyle Questions																										
<p>Do you.....(check box if your answer is yes)</p> <p><input type="checkbox"/> ..work at a computer? If yes, do you have a pair of computer glasses?</p> <p><input type="checkbox"/> ..think you might benefit from thinner, lighter lenses?</p> <p><input type="checkbox"/> ..have interest in a "test drive" of the latest contact lens designs</p> <p><input type="checkbox"/> ..spend time outdoors? How much? __Hrs/week</p> <p><input type="checkbox"/> ..have prescription sunwear?</p> <p><input type="checkbox"/> ..prefer not to wear your glasses at times?</p> <p><input type="checkbox"/> ..want information on Laser Vision Correction surgery?</p> <p><input type="checkbox"/> ..have interest in a non-surgical approach to vision correction?</p> <p><input type="checkbox"/> ..have more than 1 pair of current Rx eyewear?</p> <p><input type="checkbox"/> ..have children?</p> <p><input type="checkbox"/> ..have family members in need of eyecare?</p> <p>Have you ever experienced, been diagnosed or treated for any of the following?</p> <table border="0"> <tr> <td><input type="checkbox"/> Blurry Vision</td> <td><input type="checkbox"/> Burning</td> </tr> <tr> <td><input type="checkbox"/> Cataracts</td> <td><input type="checkbox"/> Corneal Abrasions</td> </tr> <tr> <td><input type="checkbox"/> Crossed eye/Eye turn</td> <td><input type="checkbox"/> Double Vision</td> </tr> <tr> <td><input type="checkbox"/> Eye Infections</td> <td><input type="checkbox"/> Eye Injury</td> </tr> <tr> <td><input type="checkbox"/> Flash of light</td> <td><input type="checkbox"/> Floaters/Spots</td> </tr> <tr> <td><input type="checkbox"/> Glaucoma</td> <td><input type="checkbox"/> Grittiness</td> </tr> <tr> <td><input type="checkbox"/> Headaches</td> <td><input type="checkbox"/> Iritis/Uveitis</td> </tr> <tr> <td><input type="checkbox"/> Itchiness</td> <td><input type="checkbox"/> Lazy Eye</td> </tr> <tr> <td><input type="checkbox"/> Macular Degeneration</td> <td><input type="checkbox"/> Occasional dryness</td> </tr> <tr> <td><input type="checkbox"/> Retinal Detachment</td> <td><input type="checkbox"/> Sunlight Sensitivity</td> </tr> <tr> <td><input type="checkbox"/> Tearing</td> <td><input type="checkbox"/> Trouble seeing at night</td> </tr> <tr> <td><input type="checkbox"/> Uncomfortable glasses</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other eye disorders _____</td> <td></td> </tr> </table>	<input type="checkbox"/> Blurry Vision	<input type="checkbox"/> Burning	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Corneal Abrasions	<input type="checkbox"/> Crossed eye/Eye turn	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Eye Infections	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Flash of light	<input type="checkbox"/> Floaters/Spots	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Grittiness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Iritis/Uveitis	<input type="checkbox"/> Itchiness	<input type="checkbox"/> Lazy Eye	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Occasional dryness	<input type="checkbox"/> Retinal Detachment	<input type="checkbox"/> Sunlight Sensitivity	<input type="checkbox"/> Tearing	<input type="checkbox"/> Trouble seeing at night	<input type="checkbox"/> Uncomfortable glasses		<input type="checkbox"/> Other eye disorders _____	
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The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History		
Name of Family Physician _____		
Town _____		
Date of Last Physical Check-up _____		
CURRENT MEDICATIONS (Rx or Over the Counter) (List name of medications including eye drops, vitamins, & birth control pills) _____		

Allergies to medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, what medications? _____		

Have you had any surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you use cigarettes/tobacco, alcohol, or other substances? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever been diagnosed or treated for the following health problems?		
	Yes	No
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Throat Infections	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual weight losses/gains	<input type="checkbox"/>	<input type="checkbox"/>

We see patients of all ages and are accepting new patients. Feel free to ask any of our staff about appointments for your family members.

Patient Eye History	
Date of Last Eye Exam _____	
By Whom? _____	
Have you ever tried contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you currently wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
What kind? _____	
Solutions used _____	
Are you satisfied with the vision and comfort of your contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Would you like colored or extended wear contact lenses? <input type="checkbox"/> Extended Wear <input type="checkbox"/> Colored	
If you wear bifocals, do the lines or head tilting bother you? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Family Medical/Eye History (Check all that apply)	
Is there a family medical history of any of the following:	
	Relationship (Mother's or Father's side)
Blindness	<input type="checkbox"/> _____
Cataracts	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

Please be advised if you are using insurance coverage for today's visit, this is a contract between you and your insurance company.
Statement of Financial Responsibility: I understand I am responsible to pay for services rendered, including costs of collection in the event of default, I further understand that if a payment is 30 days past due a finance charge will be added monthly to the account until paid in full. I have read this statement, understand it and agree to the conditions. Authorization is hereby granted to Windmill Eye Associates to release medical records and such information as may be requested for the completion of my claims to my insurance carrier. I further authorize payment for medical benefits to be made directly to Windmill Eye Associates.

Signature: _____