WINDSOR EYE CARE & VISION CENTER

ADULT HEALTH HISTORY

PATIENT INFORMATION

Date _____ Social Security # _____

Patient Name _____

Last First MI

Preferred Name _____

Address _____

City _____

State _____ Zip _____

Home (___) _____ Cell (___) _____

Work Phone (___) _____ ext _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birth Date _____

☐ Married ☐ Widowed ☐ Single

☐ Separated ☐ Divorced ☐ Partnered

Employed: ☐ Part Time ☐ Full Time ☐ Not Employed

Occupation _____

Employer/School _____

Spouse's Name _____

Referring Doctor: _____

How did you learn about us? ☐ Insurance ☐ Phone Book ☐ Google

☐ Website ☐ Advertisement ☐ Location ☐ Friend Name _____

Other _____

INSURANCE

Policy Holder Name _____

Policy Holder Date of Birth _____

Relationship to Patient _____

Vision Insurance _____

Medical Insurance _____

Secondary Insurance _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to

Name of Insurance Co.

Windsor Eye Care & Vision Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____

Date Relationship to Patient

REASON FOR VISIT

Date of last eye exam _____

Name of doctor _____

Do you wear glasses? ☐ Yes ☐ No

Reason for glasses

☐ All the time ☐ Distance ☐ Reading

☐ Driving ☐ Computer

☐ Other _____

Do you wear contacts? ☐ Yes ☐ No

How Often? ☐ Every day ☐ Occasionally

Do you sleep in contacts? ☐ Yes ☐ No

Are you interested in contacts today? ☐ Yes ☐ No

Current Contact Lens Brand _____

☐ Dailies ☐ 2 week ☐ Monthly

Change schedule _____ Hours/day _____

Describe any problems you have with your contacts _____

_____

Please check any vision issues you are experiencing:

☐ Blurred Vision - Distance ☐ Blurred Vision - Near

☐ Night Vision, Poor ☐ Computer Vision, Poor

☐ Recent Vision changes Other: _____

Please check any discomforts you are experiencing:

☐ Dry Eyes ☐ Eye Strain

☐ Watering Eyes ☐ Headache

☐ Itching Eyes Other _____

☐ Floaters _____

☐ Flashes _____

☐ Red Eyes

Hobbies/Sports/Interests: _____

_____

_____

_____

-OVER-

EYE HISTORY

**Please Specify: MGM (Maternal Grandmother), MGF (Maternal Grandfather), PGM (Paternal Grandmother), PGF (Paternal Grandfather), F (Father), M (Mother), S (Sister), B (Brother)*

	Yourself	Family
Color Blindness	☐Yes ☐No	☐Yes Who_____
Macular Degeneration	☐Yes ☐No	☐Yes Who_____
Glaucoma	☐Yes ☐No	☐Yes Who_____
Eye Surgery	☐Yes ☐No	Date _____

Reason for eye surgery:_____

	Yourself
Cataracts	☐Yes ☐No
Diabetic Eye Disease	☐Yes ☐No
Lazy Eye	☐Yes ☐No
Lasik	☐Yes ☐No Date _____

Other: _____

MEDICAL HISTORY

	Yourself	Family
Migraine Headaches	☐Yes ☐No	☐Yes Who_____
Arthritis	☐Yes ☐No	☐Yes Who_____
Multiple Sclerosis	☐Yes ☐No	☐Yes Who_____
Cancer (Type: _____)	☐Yes ☐No	☐Yes Who_____
Diabetes (Type: 1 or 2)	☐Yes ☐No	☐Yes Who_____
Epilepsy	☐Yes ☐No	☐Yes Who_____

	Yourself
High Blood Pressure	☐Yes ☐No
AIDS/HIV	☐Yes ☐No
Rosacea	☐Yes ☐No
Stroke	☐Yes ☐No
Thyroid Conditions	☐Yes ☐No
Seasonal Allergies	☐Yes ☐No

Are you currently pregnant? ☐Yes ☐No
Are you currently Breastfeeding? ☐Yes ☐No

Other:_____

Primary Care Physician's Name_____ **Date of last visit** _____

SOCIAL

Do you use the following items?

Alcohol	☐Yes ☐No	Frequency: _____
Marijuana	☐Yes ☐No	Frequency: _____
Tobacco	☐Yes ☐No	**Smoking** _____ packs/day **Smokeless** _____ cans/week Years used _____

MEDICATIONS

List any **MEDICATIONS**, **VITAMINS** or **SUPPLEMENTS** you are currently taking, including **EYE DROPS**: _____

_____

_____

_____

List your **allergies** to medications or other substances:

_____

_____

_____

Pharmacy Name _____

MEDICARE/MEDIGAP AUTHORIZATION

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Relationship to Beneficiary

Windsor Eye Care & Vision Center for any services furnished to me by that provider.
Name of Doctor or Clinic

To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for relates services.

_____ _____
Signature of Beneficiary, Guardian or Personal Representative Date

_____ _____
Please print name of Beneficiary, Guardian or Personal Representative Relationship to Beneficiary

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, CONTACT

Name_____ Relationship_____

Home (___) _____ Cell (___) _____ Work Phone (___) _____ ext. ____