Winrock Vision Inc

PATIENT INFORMATION

Today's date:			
Last name:	**First name:**		**M.I.:**
Marital Status:	**Date of birth:**	**Age:**	**Gender:**
Street address:		**Home phone:**	
City:	**State:**	**ZIP Code:**	**Cell phone:**
Occupation:	**Employer:**		**Work phone:**

☐ **Email Address:** (we do not send spam or junk mail or share your email address – email address will be used for appointment reminders, etc.) ☐

How did you hear about our office?	□ Family/Friend	□ Insurance	□ Drive/Walk By	□ Yellow Pages
	□ Advertisement	□ LensCrafters.com	□ Other Internet	□ Other

Other friends or family members seen here:	
Do you participate in any hobbies, sports, or special activities? (please list)	

INSURANCE INFORMATION

--Please list your vision ***and*** medical insurance. Please give your insurance card(s) to the receptionist.--

Do you have vision insurance?	□ Yes	□ No	If yes, insurance carrier:
Do you have health insurance?	□ Yes	□ No	If yes, insurance carrier:
Do you have Medicare?	□ Yes	□ No	

MEDICAL HISTORY

Do you have allergies to any medication?	□ Yes	□ No	If yes, please list here:
List any medications you take or eye drops you use, and include dosages, if known. Include over-the-counter medications, home remedies, aspirin, oral contraceptives, vitamins, etc.			
List all major injuries, surgeries, and/or hospitalizations you have had			

Are you pregnant?	□ Yes	□ No	Are you nursing?	□ Yes □ No
Approximate date of last eye exam? If you are not sure, please estimate (1 year ago, 10 years ago, etc.)				
Do you wear glasses?	□ Yes	□ No	If yes, how old is your current pair?	
Do you wear contacts?	□ Yes	□ No	If yes, how old is your current pair?	
☐ If so, what brand do you wear?			Are they comfortable?	□ Yes □ No
☐ If not, are you interested in wearing contacts?			□ Yes	□ No
What brand of solution do you use?			**How often do you replace your contacts?**	

Do you, or do any of your family members, currently have or have a history of any of the following conditions?

-SEE REVERSE SIDE-

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	SELF	FAMILY	RELATION
OCULAR			
Amblyopia / Lazy Eye	□	□	
Strabismus / Crossed Eyes	□	□	
Dry Eye	□	□	
Cataracts or Cataract Surgery	□	□	
Eye Surgery (including LASIK)	□	□	
Eye Injury	□	□	
Macular Degeneration	□	□	
Glaucoma	□	□	
Retinal Detachment / Hole / Repair	□	□	
Blindness / Loss of Vision	□	□	
Blurred Vision	□	□	
Distorted Vision / Halos	□	□	
Loss of Peripheral (side) Vision	□	□	
Double Vision	□	□	
Redness	□	□	
Sandy / Gritty Feeling	□	□	
Itching, Burning, and/or Watering	□	□	
Foreign Body Sensation	□	□	
Glare / Light Sensitivity	□	□	
Eye Pain or Soreness	□	□	
Chronic Infection of Eye or Lid	□	□	
Sties or Chalazion	□	□	
Flashes / Increase in Floaters	□	□	
Tired Eyes	□	□	
CONSTITUTIONAL			
Fever, Weight Loss / Gain	□	□	
INTEGUMENTARY			
Skin Problems	□	□	
NEUROLOGICAL			
Headaches	□	□	
Migraines	□	□	
Seizures	□	□	
ALLERGIC	□	□	

	SELF	FAMILY	RELATION
EAR, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	□	□	
Sinus Congestion	□	□	
Runny Nose	□	□	
Post-Nasal Drip	□	□	
Chronic Cough	□	□	
Dry Throat / Mouth	□	□	
RESPIRATORY			
Asthma	□	□	
Chronic Bronchitis	□	□	
Emphysema	□	□	
VASCULAR / CARDIOVASCULAR			
Diabetes	□	□	
Heart Pain	□	□	
High Blood Pressure	□	□	
Vascular Disease	□	□	
GASTROINTESTINAL			
Chronic Diarrhea	□	□	
Chronic Constipation	□	□	
GENITOURINARY			
Genital / Kidney / Bladder problems	□	□	
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis	□	□	
Muscle Pain	□	□	
Joint Pain	□	□	
LYMPHATIC / HEMATOLOGIC			
Anemia	□	□	
Bleeding Problems	□	□	
Lupus	□	□	
Cancer	□	□	
IMMUNOLOGIC	□	□	
HIV/AIDS	□	□	
PSYCHIATRIC	□	□	
ENDOCRINE			
Thyroid / Other Gland Problems	□	□	

If you answered yes to any of the above, or have a condition not listed, please explain	

SOCIAL HISTORY

Do you wear sunglasses?	□Yes □No	**Do you smoke?**	□Yes:_____packs/day □No
Do you consume alcohol?	□Yes □No	**Do you use recreational drugs?**	□Yes □No
□ If yes, how often?		□ If yes, what kind?	

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Winrock Vision Inc or insurance company to release any information required to process my claims.

Patient/Guardian signature	**Date** _____/_____/_____
Doctor's Signature	**Date** _____/_____/_____