Winchester Eye Clinic PC Welcome To Our Office

Welcome to Winchester Eye Clinic PC. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment

to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask. ☐ Male Female ☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. Preferred Name Last Name MI First Name City State Zip Street Address Home Phone - Include Area Code Day Phone Date of Birth Social Security Number Person Responsible for Account Guardian **Email Address Emergency Phone Emergency Contact** Who were you referred by? How were you referred to our office? ☐ Advertisement ☐ Patient School ☐ Phone Book ☐ Doctor Other ☐ Insurance Listing ☐ Drive by PRIMARY INSURANCE INFORMATION State Zip City Name and Address of Primary Insurance Company $M \square F \square$ MI Insured's Last Name Insured's First Name Insured's Identification Number Insured's Date of Birth Group Number ☐ Single ☐ Married ☐ Other **Patient Status** Patient Relationship to Insured ☐ Part Time Student ☐ Employed ☐ Self ☐ Spouse ☐ Child ☐ Other ☐ Full Time Student SECONDARY INSURANCE INFORMATION Name and Address of Secondary Insurance Company State Zip City $M \square F \square$ MI Insured's Last Name Insured's First Name Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other Insured's Date of Birth Insured's Identification Number Group Number Please Read: In order to control the cost of billing, we ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. We would rather control billing costs than be forced to raise our fees. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks. Payment from my insurance is to be paid directly to . I understand that will be billed as my primary insurance. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed. Notice of HIPPA Privacy Policiews: I acknowledge I have had the opportunity to read and/or receive Winchester Eye Clinic's Notice of Privacy Practices. Date Signature

Nam	ie:							
Race	P	ATIENT HISTO	DRY AND INF	ORMAT	ON			
☐ American Indian☐ Asian☐ Black Or African☐ Native Hawaiian		□ Wr □ Na	ner Race nite tive American ucasian		e To Specify isclosed	Other Ra	ce	
Ethnicity	O Hispanic Or	Latino O No	t Hispanic Or I	Latino (Unknown			
Preferred Language								
	Height ft	in cm/m	ft in Ocm (/eight		○ kg	
PRIMARY CARE PHY	(SICIAN							
Primary Care Physic	ian and Clinic Nam	ne						
Address of Primary (Care Physician	City		State Z	ip Pt	none		
REFERRING PHYSIC	IAN							
Referring Physician a	and Clinic Name							
Address of Referring	Physician	City		State Zi	D Db	one		
HEALTH HISTORY What is the main real	son for todav's exa	ım ?			n was your last) 20 4000	
When was your last h		···		vviie	n was your last	exam ? A	Apr 28, 1993	
Past Illnesses or Inju								
Past Surgeries:								
Current Medications:								
Current Eye Drops:								
Medicines that cause Specific Allergies:	reactions or sensi	tivities:						
EYE HISTORY								
Glaucoma Catarac Macular Degeneration Retinal Detachment	Yes O No	Excess Tearing/N Eye Pain or S	Dryness O Yes Vatering O Yes Goreness O Yes ensation O Yes	O No O No	rabismus (Cros Blurred Vision Blurred Vi Distorted Vision	Distance ision Near	O Yes O No O Yes O No O Yes O No O Yes O No	
Color Blindness Headaches Glare/Light Sensitivity	O Yes O No O Yes O No	Infection of Ey	e or Lid O Yes Itching O Yes	O No O No	Dou Floaters	ble Vision s or Spots	O Yes O No O Yes O No	
Tired Eyes Amblyopia (Lazy Eye)	O Yes O No	Droopin i	ischarge O Yes ig Eyelid O Yes Redness O Yes	O No		ing Vision s of Vision ide Vision	O Yes O No O Yes O No O Yes O No	
Burning	O Yes O No	Sandy or Gritty	Feeling O Yes	O No				

Name:
Fever O Yes O No Weight Loss Other Symptoms Ears, Nose, Throat Cardiovascular (high blood pressure etc.) Respiratory (Asthma) O Yes O No Gastrointestinal O Yes O No Kidney O Yes O No No Skin O Yes O No O O O O Yes O No O O O O O O O O O O O O O O O O O
Amblyopia (Lazy Eye) Blindness Cataract(s) Color Blindness Glaucoma Glaucoma Cacular Degeneration Amblyopia (Lazy Eye) O Yes O No Caternat (S) O Yes O No Cancer O Yes O No Diabetes O Yes O No O Yes O No Diabetes O Yes O No
SOCIAL HISTORY
Current Occupation : Years Employer
Description of the past with glasses? Description of the
ONTACT LENS HISTORY If not a contact lens wearer, are you interested in trying contact lenses at this time? O Yes O No
If not a contact lens wearer, are you interested in trying contact lenses at this time?
Do you currently wear contact lenses? O Yes O No Since
T
How many hours/day? Today's wearing time? How many hours/day? How many days/week?
Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT Right Left Right Left Lens Comfort Distance Vision Near Vision

Disinfectant

What Solutions do you use? Cleaner

_____ Enzyme __

Name:								
SOCIAL HISTORY								
Do you use nutritional supplements (vitamins etc.)? Do you engage in regular exercise?			O Yes O No O Yes O No					
Do you drink alcohol ? If yes, how much/often :				al O 1 Per Day O 2-3/day O 4+/day				
Do you smoke ? If yes, how r Smoking Status	much/often :			O 1/2 pack/day	O 1 pack/day	O 1+ pack		
Method of Tobacco Intake :		O Smoking O Chewing						
Do you use Illegal Drugs :	O Yes O No							
Hobbies/ Interests :								
			Ī					