Welcome to our office!

Last Name | First Name | Middle Initial | Date

Address | Home Phone

City | State | Zip | Work Phone

Date of Birth | Spouse's Name (or Parent if patient is a child) | Cell Phone

What is your occupation? | E-mail Address

HOW DID YOU FIND OUT ABOUT US? Friend (Name) _____

Physician Insurance On-line Magazine Drive-by

HEALTH INSURANCE:_____ Policy Holder:_____

VISION INSURANCE:_____ Date of Birth of Policy Holder:_____

WHAT IS THE MAIN REASON FOR YOUR VISIT?

_____ General Eye Exam

_____ New Glasses

_____ Contact Lens Exam

_____ Eye Infection/Injury

_____ Refractive Surgery / LASIK

ANY FAMILY HISTORY OF:

____ Glaucoma
____ Cataracts
____ Macular Degeneration
____ Retinal Detachment
____ Diabetes
____ Cancer – breast / prostate / metastatic
____ Heart Disease
____ High Blood Pressure
____ Kidney Disease
____ Thyroid Disease
____ Lupus
Other_____

MEDICAL HISTORY

Are you taking any medications? ____Yes_____
____ No

Are you allergic to anything? ____Yes_____
____ No

Please list all MAJOR injuries, surgeries and/of hospitalizations you have had:_____

_____

Please list any of the following you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or eye injury**:**_____

_____

SOCIAL HISTORY

Do you have any visual difficulty when driving? No Yes
If yes, please describe:_____

Do you use tobacco products? No Yes
If yes, type / amount / how long:_____

Do you use drink alcohol? No Yes
If yes, type / amount / how long:_____

Do you use illegal drugs? No Yes
If yes, type / amount / how long:_____

Have you ever been exposed to or infected with:
_____Gonorrhea _____Herpes _____Hepatitis _____Syphilis _____ HIV

REVIEW OF SYSTEMS
Do you currently, or have you ever had any SIGNIFICANT problems in the following areas:
(If you have been healthy, simply draw a line down the entire "No" columns)

ALLERGIC/IMMUNOLOGIC	No	Yes
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	No	Yes
Muscle Pain	No	Yes
Joint Pain	No	Yes
CONSTITUTIONAL		
Weight Loss/Gain	No	Yes
EARS, NOSE MOUTH, THROAT		
Allergies/Hay fever	No	Yes
Sinus Congestion	No	Yes
Post Nasal Drip	No	Yes
Chronic Cough	No	Yes
Dry Throat/ Mouth	No	Yes
ENDOCRINE		
Thyroid/Other Glands	No	Yes
EYES		
Loss of Vision	No	Yes
Blurred Vision	No	Yes
Distorted Vision/Halos	No	Yes
Loss of Side Vision	No	Yes
Double Vision	No	Yes
Dryness	No	Yes
Mucous Discharge	No	Yes
Redness	No	Yes
Itching	No	Yes
Burning	No	Yes
Foreign Body Sensation	No	Yes
Excess Tearing/Watering	No	Yes
Glare/Light Sensitivity	No	Yes
Eye Pain or Soreness	No	Yes

EYES CONTINUED		
Chronic Infections	No	Yes
Styes or Chalazion	No	Yes
Flashes/Floaters in Vision	No	Yes
GASTROINTESTINAL		
Diarrhea	No	Yes
Constipation	No	Yes
GENITOURINARY		
Genitals/Kidney/Bladder	No	Yes
INTEGUMENTARY (Skin)	No	Yes
LYMPHATIC/HEMATOLOGIC		
Anemia	No	Yes
Bleeding Problems	No	Yes
NEUROLOGICAL		
Headaches	No	Yes
Migraines	No	Yes
Seizures	No	Yes
RESPIRATORY		
Asthma	No	Yes
Chronic Bronchitis	No	Yes
Emphysema	No	Yes
VASCULAR/CARDIOVASCULAR		
Diabetes	No	Yes
Heart Pain	No	Yes
High Blood Pressure	No	Yes
Vascular Disease	No	Yes
PSYCHIATRIC	No	Yes

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

NEW DIGITAL RETINAL IMAGING

Digital Retinal Imaging allows instant viewing of retinal photographs by the doctor and the patient. This computerized technology aids us by establishing baseline photos of the inside of your eyes. We can then compare this image with future images and carefully observe any normal or abnormal changes. We believe this will promote earlier diagnosis of many abnormal eye conditions, some of which can result in permanent vision loss if not caught and treated in a timely manner.

We recommend this procedure for every adult patient. To best care for our youngest patients, we provide this service at no charge for children 12 and under.

Medical insurance companies reimburse Digital Retinal Imaging only when there is existing eye disease. All other imaging is non-reimburseable. Our fee for this service is $30.00.

_____ Please perform DIGITAL RETINAL IMAGING.

_____ I do not wish to have baseline DIGITAL RETINAL IMAGING performed.

TOWNE LAKE EYE ASSOCIATES OFFICE POLICIES

1. Payment is due when services are rendered unless other arrangements are made beforehand.
2. Patients are responsible for obtaining all information regarding their insurance.
3. Patients are responsible for any bills not paid by their insurance company after 90 days.
4. If we file insurance, patients authorize insurance benefits to be paid directly to the doctor, and understand they are responsible for non-covered services.
5. Patients are asked to pick up spectacle/contact lens orders in a timely manner. Orders will be returned after 30 days, unless otherwise advised by the patient.
6. Work with a patient's old frame is performed at the patient's own risk. Older frames may break.
7. **Contact lens patients** - if you wear contact lenses, it is necessary to have a contact lens evaluation. There is an extra fee for this service.

I am the guarantor of this account, and I have read, understand, and agree to these office policies. Further, I acknowledge that I was offered a copy of Towne Lake Eye Associates Privacy Practices.

_____ _____

Patient/Guarantor Signature Today's Date