



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 Yellow Pages 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	EYES CONTINUED		
BONES/JOINTS/MUSCLES			Chronic Infections	No	Yes
Rheumatoid Arthritis	No	Yes	Styes or Chalazion	No	Yes
Muscle Pain	No	Yes	Flashes/Floaters in Vision	No	Yes
Joint Pain	No	Yes	GASTROINTESTINAL		
CONSTITUTIONAL			Diarrhea	No	Yes
Weight Loss/Gain	No	Yes	Constipation	No	Yes
EARS, NOSE MOUTH, THROAT			GENITOURINARY		
Allergies/Hay fever	No	Yes	Genitals/Kidney/Bladder	No	Yes
Sinus Congestion	No	Yes	INTEGUMENTARY (Skin)	No	Yes
Post Nasal Drip	No	Yes	LYMPHATIC/HEMATOLOGIC		
Chronic Cough	No	Yes	Anemia	No	Yes
Dry Throat/ Mouth	No	Yes	Bleeding Problems	No	Yes
ENDOCRINE			NEUROLOGICAL		
Thyroid/Other Glands	No	Yes	Headaches	No	Yes
EYES			Migraines	No	Yes
Loss of Vision	No	Yes	Seizures	No	Yes
Blurred Vision	No	Yes	RESPIRATORY		
Distorted Vision/Halos	No	Yes	Asthma	No	Yes
Loss of Side Vision	No	Yes	Chronic Bronchitis	No	Yes
Double Vision	No	Yes	Emphysema	No	Yes
Dryness	No	Yes	VASCULAR/CARDIOVASCULAR		
Mucous Discharge	No	Yes	Diabetes	No	Yes
Redness	No	Yes	Heart Pain	No	Yes
Itching	No	Yes	High Blood Pressure	No	Yes
Burning	No	Yes	Vascular Disease	No	Yes
Foreign Body Sensation	No	Yes	PSYCHIATRIC	No	Yes
Excess Tearing/Watering	No	Yes			
Glare/Light Sensitivity	No	Yes			
Eye Pain or Soreness	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-reimbursable. Our fee for this service is \$20.00.

_____ 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