Today's Date: _____

How did you hear about our office? (Please check box and list name)

□ Friend/Relative: _____ □ Another Healthcare Provider: _____

□ Internet: _____ □ Event/Other: _____

GENERAL INFORMATION

Name (Last, First, MI, Preferred): _____ Date of Birth: _____

Address: _____ Gender: □ Male □ Female

City, State, Zip: _____

Social Security #_____

Please list your Phone #, then check which # you prefer to be contacted:

□ Home: _____ □ Work: _____ □ Cell: _____

E-mail: _____

Race (please circle): Caucasian African American Hispanic/Latino Asian Indian
Multiracial American Indian Hawaiian African Arab Unknown

Ethnicity (please circle): Hispanic/Latino Not Hispanic/Latino

Language: _____

Employer (or School): _____ Occupation (or Grade):_____

Emergency Contact and Phone #:_____

If married, name of spouse_____ If child, name of parents_____

HEALTH HISTORY:

Last eye exam: _____ Doctor/Location:_____

Do you currently wear contact lenses? □ Yes □ No. If yes, what kind?_____

Do you wear glasses? □ Yes □ No. If yes, how old are they?_____

Have you been experiencing any of the following?

□ Blurred Vision
□ Flashes
□ Floaters
□ Light Sensitivity
□ Burning/Sandy Feeling
□ Dry Eyes
□ Redness
□ Tired/Strained Eyes
□ Itching
□ Watery Eyes

Are you interested in?

□ Contact Lenses
□ Lasik
□ Computer glasses
□ Sports glasses
□ Sunglasses

Any specific visual/eyewear needs for your work or hobbies? _____

Do you currently work at a computer for long periods? How long per day? _____

Current Medications (Include over-the-counter, eye drops/meds, vitamins, oral contraceptives)

_____

_____

Have you experienced or been diagnosed or treated for: (If yes, check box and explain below)

EYES
□ Cataracts
□ Glaucoma
□ Macular Degeneration
□ Dry Eye Syndrome
□ Retinal Tear/Detachment
□ Lazy Eye
□ Eye Injury
□ Eye Surgery/LASIK

CONSTITUTIONAL
□ Developmental Disability
□ Cancer

EAR/NOSE/THROAT
□ Hearing Loss
□ Sinusitis

NEUROLOGICAL
□ Multiple Sclerosis
□ Stroke
□ Migraines
□ Concussion

PSYCHIATRIC
□ Depression
□ Anxiety Disorder
□ Bipolar Disorder

CARDIOVASCULAR
□ High Blood Pressure
□ Heart Disease
□ Vascular Disease

RESPIRATORY
□ Asthma
□ COPD
□ Sleep Apnea

GASTROINTESTINAL
□ Crohn's, Colitis

GENITOURINARY
□ Kidney Disease
□ Sexually Transmitted Disease

MUSCULOSKELATAL
□ Osteoarthritis

SKIN
□ Rosacea
□ Eczema/Psoriasis

ENDOCRINE
□ Diabetes
□ Thyroid dysfunction

HEMOTOLOGIC/LYMPHATIC
□ Anemia
□ High Cholesterol

ALLERGY/IMMUNOLOGIC
□ Rheumatoid Arthritis
□ Lupus

OTHER: _____

Please Explain: _____

Primary Physician:_____ Clinic/Location:_____Last Exam:_____

Are you currently, or is there a possibility that you may be, pregnant or nursing? □ Yes □ No

Height:_____Weight:_____

Allergies

Are you allergic to any medications? □ Yes □ No. If yes: _____

Do you have any environmental allergies/hay fever? □ Yes □ No

Social History:

Do you use any tobacco products? □ Yes □ No. How often_____. Have you ever smoked? □ Yes □ No

Do you drink alcohol? □ Yes □ No. How often_____.

Is there a family history of any of the following? (Explain relationship)

□ Glaucoma _____
□ Macular Degeneration _____
□ Cataracts _____
□ Retinal Detachment/Tear _____
□ Lazy Eye_____
□ Other Eye Disease_____

□ Type II Diabetes _____
□ Type I Diabetes_____
□ Hypertension_____
□ Cancer_____
□ Hyperthyroid_____
□ Hypothyroid_____

Dr. Amanda Winterboer
Spencer Total Family Eyecare
1104 West 18th Street
Spencer, IA 513010243
(712) 262-3331

Acknowledgment of Receipt of Notice of Privacy Practices

I (patient) have received a copy of this office's Notice of Privacy Practices.

Print Name _____

Signature_____

Date_____

I release my information to:

_____

_____

_____

_____

_____

_____

FOR OFFICE USE
We attempted to obtain written acknowledgment of the receipt of Privacy Practices, but acknowledgment could not be obtained because:
____Individual refused to sign
____An emergency situation prevented us from obtaining acknowledgment.
____Other

Spencer Total Family Eyecare, P.C.
Amanda Winterboer, O.D.
1104 W 18th Street
Spencer, IA 51301

Financial Responsibility

To our patients with Medical and/or Vision benefits:

We will be happy to file your insurance claims forms or take assignment on your medical/vision benefits as designated by the:

Plan(s) of which you are a member. We will do all we can to help you receive the maximum benefits. However, in the event that the plan sponsor determines that you are not eligible for the coverage at the time of service, or makes the determination that you are eligible for a reduced level of coverage. By signing this statement, you hereby agree to be financially responsible for any and all charges incurred by you and not paid by the plan sponsor.

_____ _____

Signature of patient or person acting on patient's behalf Date