Welcome to Windmill Eye Associates

What is the main reason for your visit today?		Today's Date:	Gender: □ Male □ Female
Patient Last Name:	Patient First Name:	Patient SSN:	Date of Birth:
Name of Parent/Guardian(If Applicable):			
Street Address:		City:	State: Zip:
Email Address:		Employer/School Name:	Occupation or Grade:
Home Phone:	Cell Phone:	Work Phone:	□ English □ Spanish
Preferred Phone: □ Home Phone □ Cell Phone □ Work Phone		Preferred Contact Method: □ Email □ Text Message □ Mail □ Phone	
Referred By:			

Doctor/Clinic of Last Eye Exam:		**Date of Last Eye Exam:**	
	Do you currently use glasses?		Do you currently wear contact lenses?
	Do you want info on LASIK/PRK?		If not, would you like to?
	Have you had LASIK/PRK? Year: Dr:		Do you sleep in your contact lenses?

Name of Family Physician:			**Phone:**		
Please check if you have a history of any of the following:					
	Eye injury or surgery		Cataract		Autoimmune disease
	Retinal detachment/holes		Cataract Surgery		Thyroid Disease
	Flashes		Cancer		Alcohol Use
	Floaters		Diabetes		Tobacco Use
	Eye Turn/Amblyopia		High blood pressure		Learning/Reading Difficulties
	Dry Eye		High cholesterol		Other:
	Macular degeneration		Heart Disease		
	Glaucoma		Anxiety/Depression		
List all medications you are currently taking, including eye drops and over the counter supplements:					

Family Medical & Eye History

Please check if any family members have a history of the following (if yes, please note relationship to you):					
	Cataract		Retinal detachment		Heart disease
	Glaucoma		Diabetes		High blood pressure
	Macular Degeneration		Cancer		High cholesterol
	Eye Turn/Amblyopia		Thyroid Disease		Other _____
List any allergies to medications:					

Insurance Information

Vision Insurance _____ Subscriber's Name _____
Subscriber's Date of Birth _____ Employer _____
Subscriber's SSN _____ Insurance ID # _____

The eye health portion of your examination may be billable to your medical insurance.

Medical Insurance _____ Subscriber's Name _____
Subscriber's Date of Birth _____ Employer _____
Subscriber's SSN _____ Insurance ID # _____

Please Initial Each of the Following Sections:

_____ **Payment Policy:** By making an appointment at Windmill Eye Associates, you are agreeing to abide by all billing policies of our practice. Payment is required at the time services are rendered or materials are ordered. Quotes of insurance coverage are based on information from the insurance company and are not guaranteed. Although we will gladly bill insurance for you, the patient remains responsible for their charges even after the insurance has been billed. If payment has not been received from insurance after 60 days, the patient will be expected to pay Windmill Eye Associates directly.

_____ **Financial Responsibility**: I understand that I am personally responsible for payment of my account even if I have insurance. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay all costs and expenses including reasonable attorney's fees.

_____ **Cancellation Fee:** A cancellation charge of $25 will be billed to you personally if you do not provide at least 24 hours' notice of a cancellation or change in your in your appointment date or time.

_____ **Photograph Release:** I hereby consent to photographs being taken for my medical record and to be shared on Windmill Eye Associates social media. (Optional)

_____ **Release of Information:** I hereby authorize release of my information to my insurance company or to any health care professional or education professional when necessary for my health care billing. (This allows us to bill your insurance.)

_____ **Privacy Policy:** We respect our legal obligation to keep health information private. We are obligated by law to give you notice of our privacy practices. If you would like to receive a copy of our Notice of Privacy Practices, please request one from the receptionist today or at any time in the future. I understand that Windmill Eye Associates has a Notice of Privacy Practices available for my review if I wish. At the present time, I acknowledge that this notice has been offered and I accept the Notice of Privacy Practices.

_____ These policies will be enforced for both new patients and established patients. Our staff will be happy to answer any further question regarding these policies.

Signed (Patient/Patient Representative): _____ Date: _____

Description of Representative's Authority _____