Wynne Eye Associates

Dr. Kevin B. Wynne **Dr. Frederick J. Fouquet**

WELCOME TO OUR OFFICE
Patient History Form

Today's date _____
Last Name _____ First Name _____ MI _____
Address _____ City _____ State _____ Zip _____
Telephone (home) (_____)_____ Work (_____)_____
Cell Phone (_____)_____
Date of Birth _____
Occupation _____ Employer _____
Insurance Company _____ Policy Number _____
Subscriber _____ Subscriber's date of Birth _____
Emergency Contact Name _____ Phone (_____)_____
Whom may we thank for referring you? _____
Date of your last comprehensive eye exam? _____

MEDICAL INFORMATION

Do you have problems with any of these systems? (Please circle all that apply)

Gastrointestinal	Y/N	Nervous	Y/N	Eyes	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Skin	Y/N	Mental	Y/N

Please explain _____
Please answer all that apply:
Current Medications _____
Are you allergic to any medication(s)_____
Diabetes Y/N Type _____ Date of Diagnosis _____
High Blood Pressure Y/N
High Cholesterol Y/N
Other health Problems _____
Have you had any surgeries? Y/N Kind?_____
Cigarette/Tobacco Use Y/N Alcohol Y/N Other Substance(s) Y/N
Name of Family Doctor _____ Date of Last Visit _____

PLEASE TURN OVER AND COMPLETE FORM ON BACK

FAMILY HISTORY

High Blood Pressure Y/N Relation _____ Cataracts Y/N Relation _____
Diabetes Y/N Relation _____ Glaucoma Y/N Relation _____
Macular Degeneration Y/N Relation _____
Retinal Detachment Y/N Relation _____
Other Eye Conditions Y/N Please Explain _____

PERSONAL EYE INFORMATION

Have you had any eye surgeries? Y/N Type_____ Date _____
Have you had any eye injuries? Y/N Type _____Date _____
Do you have Glaucoma? Y/N Cataracts? Y/N
Other Eye Problems? Y/N Please Explain _____
Do you wear glasses? Y/N Contact Lenses? Y/N
Are you interested in contact lenses? Y/N
Are you satisfied with your distance and reading vision? Yes or No
Do you wear sunglasses? Yes or No
How many hours a day do you use a computer? _____
Do your eyes bother you when working on a computer, watching TV or reading? Yes or No
Do your eyes feel dry, sore, or tired? Yes No Sometimes
Do you use artificial tears? Yes No Sometimes

MEDICAL RELEASE/LIFETIME SIGNATURE ON FILE/PAYMENT AUTHORIZATION

I authorize payment of all Medicare or other insurance benefits for services rendered by this office to be made payable to the doctors in this office. I authorize this office to release to the Health Care Financing Administration and its agents and any other insurer any information necessary to determine the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. I understand that I am responsible for all charges not covered by insurance benefits. I hereby give my consent for myself or my child to be examined. I understand that my eyes may be dilated during examinations. If a refraction (the part of the exam that determines your need for eyeglasses) is necessary, Medicare and certain other insurance carriers will/may disallow it, stating that it is not a covered Medicare/insurance benefit. Therefore, I will be responsible for the refraction charge as well as for any other "non covered" services under Medicare and other private insurance plans. In the case where multiple insurance benefits may be applied, this office reserves the right to choose which insurance may be deemed primary. In the event that multiple insurance benefits apply, this office will limit their filing to two separate claim filings with myself being responsible for any further filings.

Signature _____ Relationship _____Date _____