Welcome to Dr. Woodfield & Associates

Arrival time: _____ ☐ New Patient
Time Out: _____ ☐ Previous Patient
☐ Walk-in

GENERAL INFORMATION

Patient's Full Name _____ Date of birth _____ ☐ Male ☐ Female

Address _____ Home Phone: _____

City _____ State _____ Zip _____ Mobile Phone: _____

Occupation _____ Employer _____ Work Phone: _____

E-mail Address _____

Hobbies _____

How did you hear about our office? ☐ Family / Friend ☐ Phone Book ☐ Website ☐ Other: _____

PHYSICIAN INFORMATION

Physician's Name _____ Date of Last Physical _____ Office Phone: _____

INSURANCE INFORMATION

Primary Insurance _____ Secondary Insurance _____

Responsible Party _____ Social Security No. _____

MEDICAL HISTORY

Please list any medications you are taking: _____

_____

_____

Do you have any allergies to medications? ☐ Yes ☐ No If yes, explain: _____

_____

List all major injuries, surgeries and / or hospitalizations you have had: _____

_____

When was your last eye exam? _____ Location: _____

Check if you have had the following: ☐ Drooping Eyelid ☐ Glaucoma ☐ Retinal Disease ☐ Crossed Eyes
☐ Eye Infection ☐ Eye Injury ☐ Eye Surgery ☐ Cataracts ☐ Lazy Eye

Are you pregnant and / or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? _____

Type of contact lenses: ☐ Hard ☐ Soft ☐ Extended Wear ☐ Other _____ Are they comfortable? _____

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, or children) for the following:

Yes	No	Condition	Relationship to You
		Blindness	
		Cataract	
		Crossed Eyes	
		Glaucoma	
		Macular Degeneration	
		Retinal Detachment / Disease	
		Arthritis	
		Cancer	
		Diabetes	
		Heart Disease	
		High Blood Pressure	
		Kidney Disease	
		Lupus	
		Thyroid disease	
		Other	

POLICIES AND PROCEDURES

PUPIL DILATION: If you have symptoms of light flashes, spots, or shadows, or if you are over 40, you should have your pupils dilated. Dilating the pupils allows us to more thoroughly examine the health of your eyes. There is an additional charge for this service. Please indicate if you want this service by initialing.

_____
Initials

PAYMENT POLICY: Our office policy is to ask for payment at the time of service. We do not accept insurance in lieu of payment unless we are a participating provider. We will be happy to assist you so that your insurance company reimburses you directly. We do not bill for services rendered or materials dispensed. Contact lenses must be paid in full before they will be dispensed to you.

AUTHORIZATION: I give permission to Dr. Woodfield & Associates to examine and treat me (or my child) and agree to pay for all services rendered and all materials dispensed regardless of insurance coverage.

_____
Signature Date

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

☐ Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No If yes, please describe:

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

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

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

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

System	Yes	No	?
Constitutional			
Fever, Weight Loss / Gain			
Integumentary (Skin)			
Neurological			
Headaches			
Migraines			
Seizures			
Eyes			
Loss of Vision			
Blurred Vision			
Distorted Vision / Halos			
Loss of Side Vision			
Double Vision			
Dryness			
Mucous Discharge			
Redness			
Sandy or Gritty Feeling			
Itching			
Foreign Body Sensation			
Excess Tearing / Watering			
Glare / Light Sensitivity			
Eye Pain or Soreness			
Chronic Infection of Eye or Lid			
Sties or Chalazion			
Flashes / Floaters in Vision			
Tired Eyes			
Endocrine			
Thyroid / Other Glands			

System	Yes	No	?
Ears, Nose, Mouth, Throat			
Allergies / Hay Fever			
Sinus Congestion			
Runny Nose			
Post-Nasal Drip			
Chronic Cough			
Dry Throat / Mouth			
Respiratory			
Asthma			
Chronic Bronchitis			
Emphysema			
Vascular / Cardiovascular			
Diabetes			
Heart Pain			
High Blood Pressure			
Vascular Disease			
Gastrointestinal			
Diarrhea			
Constipation			
Genitourinary (Genitals / Kidney / Bladder			
Bones / Joints / Muscles			
Rheumatoid Arthritis			
Muscle Pain			
Joint Pain			
Lymphatic / Hematologic			
Anemia / Bleeding Problems			
Allergic / Immunologic			
Psychiatric			

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

_____

_____

_____

_____

_____

_____
Doctor's Signature Date