Welcome to Our Office

Drs. Schindler, Deis, & Hellebush

General:

Patient's Name: _____ Date of Birth: __/__/__
First MI Last

Preferred Name (Nickname): _____ Gender: M F

Address: _____
Street Apt. No. City State Zip

Phone Numbers (Please check # you prefer us to contact you between 8 am – 5 pm M-F)

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

□ Other: _____ Email: _____

Preferred Language:_____

Race: ___ American Indian or Alaska Native ___ Asian ___ Black or African American ___ White
___ Native Hawaiian or Other Pacific Islander ___ Unknown ___ Other: _____

Ethnicity: ___ Hispanic or Latino ___ Non-Hispanic or Latino

Employer: _____ Position:_____

Spouse (Name, Phone): _____

Mother (Of Minor Child): _____
Name, Address, Phone #

Father (Of Minor Child): _____
Name, Address, Phone #

Personal:

Reason for Visit: _____ Concerns: _____

Do you wear glasses?: Y N Do you wear contact lenses? Y N

Brand of Contact Lenses: _____

Date of last eye exam: _____ Previous eye doctor: _____

How old is your current prescription?: _____

Current Medications: _____

_____

_____

Allergies: _____

General Physician_____

Do you have/had (check all that apply):

□ Diabetes □ Thyroid Disorder □ Heart Disease □ High Blood Pressure □ Arthritis

□ Emphysema/ Asthma □ Glaucoma □ Macular Degeneration □ Cataracts

□ Eye Surgery (If yes, dates of surgery) _____

□ Other (please explain): _____

Additional:

Whom may we thank for referring you to our office? _____

I authorize Dr. Schindler, Dr. Deis, and/or Dr. Hellebush to release my information required to process my insurance claims. I also authorize my insurance benefits to be paid directly to this office if Dr. Schindler, Dr. Deis, and/or Dr. Hellebush are providers. I understand all fees not covered are due upon completion of exam or treatment.

Signature: _____Date: _____