Kathryn Winkler, MD
Ophthalmology
Oculoplastic Surgeon

Des Plaines Eye Physicians and Surgeons, Ltd.

Welcome to our practice!

We look forward to seeing you! Our mission is excellence in clinical care and customer service. Please contact us at 847-299-5501 if we can be of assistance.

We have scheduled you an appointment for: ________________________________ with Dr. Kathryn Winkler

on ____
Day Date Time

Please note your appointment on this day is for a consultation only. Additional treatment and/or surgery, if needed, will be determined by the doctor and scheduled separately.

We ask that your arrive fifteen (15) minutes before your scheduled appointment to streamline the new patient registration process. To help us meet your entire healthcare needs, please fill out the enclosed forms completely and bring them with you to your appointment. You will also need to have your insurance card and a photo I.D. at the time of your visit or your appointment must be rescheduled. To allow yourself and the doctor enough time for this consultation, be prepared to spend up to two (2) hours in our office.

If you are a contact lens wearer, please bring your contact lens case, solution and glasses as we may ask you to remove your contact lenses for this consultation.

You are responsible for your office visit, consultation fee and/or insurance deductible. If you have health insurance coverage, please bring all medical insurance cards and forms necessary for us to bill your insurance. If you do not have this coverage please be prepared to pay the day of your appointment. We accept cash, check, and most credit cards.

If you are enrolled in a managed care health plan (HMO), you will need a referral or authorization from your Primary Care Physician (PCP) prior to your appointment in our office. If authorization is not obtained, you will be responsible for the bill.

Please be sure to list all of your medications, both prescriptions and over the counter with dosages as well as any supplements you take on the attached "Medication List" and bring it with you to your appointment.

We look forward to seeing you!

940 Lee St.
Des Plaines, IL 60016
Phone: 847-299-5501
Fax: 847-299-5505

Patient Information Sheet

Please print the following information. All information given will remain strictly confidential.

PERSONAL INFORMATION:

Patient Name:____ Date of Birth:___________

Address:_____________________________ City:______________ State:_____ Zip:________

Home Phone:(______)_________________ Cell Phone: :(______)_________________

Email address:_____________________________________

Social Security No: ______-______-______ Gender (Please circle): Male / Female / Non-Binary

(Circle one): Married (Spouse's Name:____________________) / Divorced / Single / Widowed / Other

Alternate Contact:_____________________________________ Relationship:_________________________

Alternate Contact Phone No: :(______)_______________

INSURANCE INFORMATION: (Please fill out if the PATIENT is NOT the main cardholder of the primary, secondary or tertiary insurance)

Name:____ Relation:__________________________
Date of Birth:__________________ Social Security No: ______-______-______
Address (if different from patient):____
City:_____________________________ State: _____ Zip:______________ Phone:(______)_______________

EMPLOYMENT

Employer's name:____Phone:(______)_______________
May we contact you at work? Yes / No Retired? Yes / No

PHYSICIAN INFORMATION

- Referring Physician

Name:____ Phone:(______)_______________
Address:_____________________________________City:_________________State: _____ Zip:___________

- Primary Care/Internist (If different from referring physician)

Name:____ Phone:(______)_______________

- Cardiologist

Name:____ Phone:(______)_______________

WORKER'S COMPENSATION OR AUTOMOBILE ACCIDENT RELATED: YES / NO

Name of company:____ Phone:(______)_______________
Address:_____________________________________City:_________________State: _____ Zip:_____________
Policy Holder:____ Agent Name:________________________
Case/Claim No:_______________________________________ Date of accident/injury:____________________

I hereby certify that all the information given above is true and accurate to the best of my knowledge.
SIGNED:____ **Date:**____________

(Patient, parent of minor or legal representative)

HISTORY AND EVALUATION

****PLEASE CHECK THOSE THAT APPLY**

EYE HISTORY

Glasses Contacts Glaucoma Dry eye
Cataracts Retina Macular degeneration

Previous eye surgeries: ______________________________

____

RESPIRATORY

Asthma Bronchitis COPD Emphysema
Sleep apnea/CPAP Sarcoidosis

Other:____

RENAL

Bladder/Kidney Disease Kidney Stones

Other:____

SKIN CONDITIONS

Skin cancer: Location______________________________

Rosacea Eczema Psoriasis

Other:____

HEART

Hight Blood Pressure Angina/chest pain
Congestive Heart Failure Stents
Mitral valve prolapse/murmur Heart Attack
Pacemaker/Defibrillator Arrhythmia/A. fib
Bypass Other:______________________________

STOMACH

Hiatal hernia/GERD Diverticulitis Ulcers

Other:____

ALLERGIES

Egg Latex Betadine

Other:____

____

____

____

PREVIOUS SURGERIES (Please list below)

Any problems with anesthesia?

No Yes______________________________

____

____

____

____

____

____

____

____

Date completed:____________

Name:____

Date of Birth:____________ Height:__________

Weight:__________

____

____

EARS, NOSE, THROAT

Limited mouth/neck motion TMJ history Denture
Chipped/loose teeth Ringing in ears
Deviated septum

Other:____

ENDOCRINE

Diabetes? No Yes How long?________________

Insulin dependent? No Yes Diet controlled

Thyroid disorder. What type?____________________

NEURO

Stroke Fainting Spells Seizures Bell's palsy
Numbness Myasthenia Gravis Other__________

BLOOD DISORDERS

Anemia Sickle Cell Anemia Hepatitis
Leukemia HIV/AIDS

Other:____

MUSCULOSKELETAL

Back Pain Arthritis Headaches/Migraines

Assistive devices: Cane / Walker / Wheelchair

Implantable devices

Other:____

____

FAMILY HISTORY

Thyroid Heart disease Diabetes Cancer
Skin Cancer

OTHER

Smoker: No Former; When quit?________________
Yes; How long?_____ How much?________

Drug use: No Yes:__________________________

Alcohol: No Yes; How much?________________

Occupation:____________________________________

CANCER

History of cancer? No Yes

Type of cancer and treatment:

____

____

____

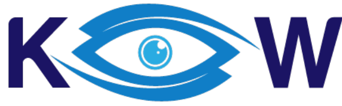
____

____

MEDICATION LIST

Date:_________ Patient Name:____
Allergies:____

Start Date	Medication/Vitamin/Herbal Sup/Aspirin	Dosage/Direction/Amount



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Dear Patient,

In addition to the medical procedures offered by our practice, Dr. Winkler also offers a number of appearance enhancing cosmetic procedures and products (listed below). Please check any of the below for which you would like more information at your visit:

Upper Eyelid Blepharoplasty (Plastic Surgery of the Upper Eyelids)

Lower Eyelid Blepharoplasty (Plastic Surgery of the Lower Eyelids)

Endoscopic Brow and Forehead Lifting

BOTOX™ *(for fine lines or wrinkles)*

Facial Fillers (Such as Juvederm™)

Latisse™ (eyelash enhancer)

Your Eyes. Your Face. Our Passion.