PLEASE COMPLETE BOTH SIDES OF THIS QUESTIONNAIRE.

WELCOME

STEP 1	PATIENT REGISTRATION

Patient ______________________________

Address ______________________________

____

City State Zip

Home phone number ______________________________

Work phone number ______________________________

Email Address ______________________________

Sex ☐ M ☐ F Birthdate ______________

Social Security Number ______________________

Occupation ______________________________

Employer ______________________________

Employer Address ______________________________

Employer Phone ______________________________

Spouse's Name ______________________________

Birthdate ______________ SS# ______________________

Spouse's Employer ______________________________

IN CASE OF EMERGENCY, CONTACT

Name ______________________________

Phone number H ______________ W ______________

Relationship ______________________________

STEP 2	INSURANCE/GUARANTOR

Who is responsible for this account? ______________________

Relationship to Patient ______________________________

Birthdate __________ SS# ______________________

Insurance Company ______________________________

ID # ______________________ Group # ______________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________________________

Birthdate ______________ SS# ______________

Relationship to Patient ______________________________

Insurance Company ______________________________

ID# ______________________ Group # ______________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ______________ and assign directly to Orgain Family Vision Care all insurance benefits, if any, otherwise payable to me for services rendered**. I understand that I am financially responsible for all charges whether or not paid by insurance, including any fees acquired to collect the balance of my bill.** I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ______________

Responsible Party Signature Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Orgain Family Vision Care for services furnished me by Orgain Family Vision Care. I authorize any holder of medical information about me to release to the Division of Medicare and Medicaid Services and its agents any information needed to determine those benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. . If "other health insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and non-covered services. Coinsurance and the deductible are based upon the charge determination of Medicare carrier.

______________________________ ______________

Beneficiary Signature Date

STEP 3	MEDICAL HISTORY OUESTIONNAIRE

MEDICATIONS

- ______________________ ■ ______________________
- ______________________ ■ ______________________
- ______________________ ■ ______________________

Allergies ______________________________

Describe all serious illness, injuries and surgeries:

____

____

____

____

PRIMARY CARE PHYSICIAN INFORMATION

Name ______________________________

Address ______________________________

____

Phone Number ______________________________

Fax Number ______________________________

OVER

STEP 3	MEDICAL HISTORY QUESTIONNARIE (continued)

FAMILY HISTORY

Please note any family member with the following diseases/conditions: M-mother F-father S-sibling GP- grandparent

		YES	NO			YES	NO
Arthritis	_____	☐	☐	Diabetes	____	☐	☐
Blindness	_____	☐	☐	Glaucoma	____	☐	☐
Cancer	_____	☐	☐	Heart Dis	____	☐	☐
Cataracts	_____	☐	☐	Hypertens.	____	☐	☐
Crossed Eyes	___	☐	☐	Retinal Dz.	____	☐	☐

SOCIAL HISTORY

Health Habits

Check which substances you use and the consumption.

	YES	NO
Alcohol	☐	☐
Quantity: ___________		
Drugs	☐	☐
Quantity: ____________		
Tobacco	☐	☐

Social History

Please indicate hobbies and Interest:

	YES	NO
Computers	☐	☐ hr_____
Fishing	☐	☐
Golfing	☐	☐
Hunting	☐	☐
Music	☐	☐
Reading	☐	☐

Do you wear:

Glasses ☐ ☐ Contact Lenses ☐ ☐ soft/gas perms Sunglasses ☐yes ☐ no

REVIEW OF SYSTEMS

Check the symptoms and/or conditions you currently have or have had in the past.

EYES	YES	NO	UNKNOWN
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eyes	☐	☐	☐
Distorted Vision (Halos)	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Glaucoma	☐	☐	☐
Infection of Eye or Lid	☐	☐	☐
Itching	☐	☐	☐
Lazy Eye	☐	☐	☐
Loss of Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Retinal Disease	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Styes or Chalazion	☐	☐	☐
BONE/JOINT/MUSCLES			
Arthritis	☐	☐	☐
Joint/Muscle Pain	☐	☐	☐
Polio	☐	☐	☐
CANCER			
Breast	☐	☐	☐
Lung	☐	☐	☐
Prostate	☐	☐	☐
Skin	☐	☐	☐
CONSTITUTIONAL			
Fever	☐	☐	☐
Weight Gain/Loss(Sudden)	☐	☐	☐
ENDOCRINE			
Thyroid Abnormalities	☐	☐	☐
EAR, NOSE AND THROAT			
Allergies	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Mouth/Throat	☐	☐	☐
Hay Fever	☐	☐	☐
Runny Nose	☐	☐	☐
Sinus Congestion	☐	☐	☐

GASTROINTESTINAL (Stomach)	YES	NO	UNKNOWN
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Ulcers	☐	☐	☐
GENITOURINARY			
Chlamydia	☐	☐	☐
Gonorrhea	☐	☐	☐
Kidney Disease	☐	☐	☐
Syphilis	☐	☐	☐
INTEGUMENTARY (Skin)			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
AIDS	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Disorders	☐	☐	☐
Hepatitis	☐	☐	☐
Herpes	☐	☐	☐
HIV Positive	☐	☐	☐
Liver Disease	☐	☐	☐
NEUROLOGIC			
Epilepsy	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Seizures	☐	☐	☐
PSYCHIATRIC			
Depression	☐	☐	☐
High Anxiety	☐	☐	☐
REPRODUCTIVE			
Nursing Mother	☐	☐	☐
Pregnant	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Pneumonia	☐	☐	☐
VASCULAR			
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐

Reviewed:___/___/___ by:_____________
Reviewed:___/___/___ by:_____________
Reviewed:___/___/___ by:_____________

Reviewed:___/___/___ by:_____________
Reviewed:___/___/___ by:_____________
Reviewed:___/___/___ by:_____________