WELCOME

Please complete both sides of this questionnaire by following the three steps.

Step 1: PATIENT REGISTRATION

Patient _____

Address _____

_____

City State Zip

Home Phone # _____

Work Phone # _____

Cell Phone # _____

Sex : ☐ M ☐ F Birthdate: _____

SSN # _____

Occupation :_____

Employer:_____

Employer Phone:_____

Spouse's Name_____

Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Phone H _____ W _____

Step 2: INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient _____

Birthdate _____ SSN _____

Insurance Co _____

Secondary Coverage? _____

ASSIGNMENT AND RELEASE/MEDICARE AUTH.

I, the undersigned certify that I (or my descendant) have insurance coverage with the above company and assign directly to Dr. Temple's office 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.** 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. (In regards to Medicare, the above is also true.)

_____

Responsible Party Signature Date

_____

Beneficiary Signature Date

Step 3 MEDICAL HISTORY QUESTIONNAIRE

PAST PERSONAL HISTORY

CURRENT LIST OF MEDICATIONS

•_____ •_____ •_____ •_____

•_____ •_____ •_____ •_____

Allergies/Medication Allergies:_____

_____

Primary Care Physician:_____

Describe all serious illnesses, injuries, and surgeries, including the eyes:

_____

_____

_____

_____

_____

☐ I currently wear glasses ☐ I currently wear soft contact lenses ☐ I currently wear RGP (Hard) contact lenses

☐ My glasses are broken/lost ☐ My most recent prescription isn't working well for me ☐ I am interested in contact lenses

Email Address:_____ (may be used for important correspondence)

Step: 3 MEDICAL HISTORY QUESTIONNAIRE (cont.)

Family History

Please note any family member with the following conditions:
M=mother, F=father, S=sibling, GP=grandparent

	YES	NO		YES	NO
Arthritis _____	☐	☐	Diabetes _____	☐	☐
Blindness _____	☐	☐	Glaucoma _____	☐	☐
Cancer _____	☐	☐	Heart Disease_____	☐	☐
Cataracts _____	☐	☐	Hypertension _____	☐	☐
Crossed eyes ____	☐	☐	Retinal Disease _____	☐	☐

Social History

Health Habits
Check which substances you use and the amount:

	YES	NO
Alcohol	☐	☐
Quantity:_____		
Drugs	☐	☐
Quantity:_____		
Tobacco	☐	☐
Quantity:_____		

Social History
Please indicate hobbies and interests:

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

REVIEW OF SYSTEMS

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

	YES	NO	UNKNOWN
EYES			
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eyes	☐	☐	☐
Distorted Vision (Halos)	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
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	☐	☐	☐
BONE/JOINT/MUSCLE			
Arthritis	☐	☐	☐
Joint/Muscle Pain	☐	☐	☐
Polio	☐	☐	☐
CANCER	☐	☐	☐
Breast	☐	☐	☐
Lung	☐	☐	☐
Prostate	☐	☐	☐
Skin	☐	☐	☐
CONSTITUTIONAL			
Fever	☐	☐	☐
Weight Gain/Loss (Sudden)	☐	☐	☐
ENDROCRINE			
Thyroid Abnormalities	☐	☐	☐
EAR, NOSE AND THROAT	☐	☐	☐
Allergies	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Mouth/Throat	☐	☐	☐
Hay Fever	☐	☐	☐
Runny Nose	☐	☐	☐
Sinus Congestion	☐	☐	☐

	YES	NO	UNKNOWN
STOMACH			
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	☐	☐	☐
Tuberculosis	☐	☐	☐
VASCULAR			
Diabetes	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐

FOR DOCTOR'S USE:

Reviewed: ____/____/____ TT SC Reviewed: ____/____/____ TT SC Reviewed: ____/____/____ TT SC

Reviewed: ____/____/____ TT SC Reviewed: ____/____/____ TT SC Reviewed: ____/____/____ TT SC

Reviewed: ____/____/____ TT SC Reviewed: ____/____/____ TT SC Reviewed: ____/____/____ TT SC

I understand that ROUTINE VISION services (routine eye exams, contact lens exams, contact lens evaluations, frames, lenses, contact lenses, etc.) are payable at the time of service, unless there is a vision benefit available on my insurance plan. I also understand that for my eye exams to be a "ROUTINE EYE EXAM". I cannot present with a problem or a diagnosis except those relating to a glasses or contact lens prescription (nearsighted, farsighted, etc.). I understand that if I have been diagnosed with a medical diagnosis which might affect my eyes (such as diabetes, hypertension, etc..) then my eye exams will be considered a MEDICAL EYE EXAM not a ROUTINE EYE EXAM. I understand that Routine Eye Exams are billable to Vision Insurance Plans, and Medical Eye Exams are billable to Medical Insurance Plans.

Initials: _____ *Date*_____

ACKNOWLEDGEMENT OF RECEIPT (Privacy Policy)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and idirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received a copy of Dr. Tabitha Temple's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (printed): _____

Relationship to Patient: _____ (self/parent/guardian etc)

Signature: _____

Date: _____

Thank you! We look forward to serving your family's eye care needs.

How did you hear about us? Friend/Family - Insurance List - Yellow Pages - Building/Sign - Radio Newspaper - Website - Other:_____