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

Person 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 QUESTIONNAIRE (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:_____________

Patient Name:________________________________

So that we may provide you with the best health care possible, please provide us with the following information. Many insurance companies require we report this information as well.

Height :________ Weight:_________ Blood Pressure:___________

Race: □ American Indian or Alaska Native
□ Asian □ Black
□ Hispanic □Native Hawaiian/Other Pacific Island
□ White

Ethnicity: □ Hispanic or Latino □Native Hawaiian/Other Pacific Island
□ Not Hispanic or Latino

Preferred Language: □ English □Spanish

We also provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request Appointments Online •Submit Patient Satisfaction Surveys
- Confirm Appointments via Email • Refer Your Friends Online
- Receive Text Message Appointment Reminders

You may opt-out of communications at any time by clicking the unsubscribe link in the footer of each email or by replying to a text message with 'STOP'. Standard Text Messaging rates apply.

Cell Phone Number :______________________ opt in opt out

Email address:__________________________ opt in opt out

(If you are under 18 please use your parent/guardian email and/or cell phone number)