

WELCOME



PLEASE COMPLETE BOTH SIDES OF THIS QUESTIONNAIRE BY FOLLOWING THE THREE EASY STEPS IN BLACK INK.

| | |
|--------------------------------------|---|
| Step 1 | PATIENT REGISTRATION |
| Patient _____ | |
| Address _____ | |
| _____ | |
| City | State |
| Zip | |
| Home / Cell number _____ | |
| Work phone number _____ | |
| Email Address _____ | |
| Sex | <input type="checkbox"/> M <input type="checkbox"/> F |
| Birthdate | _____ |
| Social Security number _____ | |
| Occupation _____ | |
| Employer _____ | |
| Employer Address _____ | |
| Employer Phone _____ | |
| Spouse's Name _____ | |
| Birthdate | _____ SS# _____ |
| Occupation _____ | |
| Spouse's Employer _____ | |
| IN CASE OF EMERGENCY, CONTACT | |
| Name _____ | |
| Relationship _____ | |
| Phone number | H _____ W _____ |

| | |
|---|------------------|
| Step 2 | INSURANCE |
| Who is responsible for this account? _____ | |
| Relationship to Patient _____ | |
| Birthdate _____ SS# _____ | |
| Insurance Company _____ | |
| Group number _____ | |
| Is patient covered by additional insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Subscriber Name _____ | |
| Birthdate _____ SS# _____ | |
| Relationship to Patient _____ | |
| Insurance Company _____ | |
| Group number _____ | |
| ASSIGNMENT AND RELEASE | |
| I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to McClurg Vision Center 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. | |
| _____ | _____ |
| Responsible Party Signature | Date |
| MEDICARE AUTHORIZATION | |
| I request that payment of authorized Medicare benefits be made on my behalf to McClurg Vision Center for services furnished me by McClurg Vision Center. 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 the Medicare carrier. | |
| _____ | _____ |
| Beneficiary Signature | Date |

| | |
|--|--------------------------------------|
| Step 3 | MEDICAL HISTORY QUESTIONNAIRE |
| PAST PERSONAL HISTORY | |
| MEDICATIONS | |
| ▪ _____ | ▪ _____ |
| ▪ _____ | ▪ _____ |
| ▪ _____ | ▪ _____ |
| Drug Allergies _____ | |
| Describe all serious illnesses, injuries and surgeries: | |
| _____ | |
| _____ | |
| _____ | |
| PRIMARY CARE PHYSICIAN INFORMATION | |
| Name _____ | |
| Address _____ | |
| _____ | |
| Phone Number | FAX _____ |

Step 3

MEDICAL HISTORY QUESTIONNAIRE (cont.)

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 | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | <input type="checkbox"/> |
| Crossed Eyes | <input type="checkbox"/> | <input type="checkbox"/> | Retinal Dz. | <input type="checkbox"/> | <input type="checkbox"/> |

SOCIAL HISTORY

Health Habits

Check which substances you use and the consumption.

| | YES | NO |
|-----------------|--------------------------|--------------------------|
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> |
| Quantity: _____ | | |
| Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| Quantity: _____ | | |
| Tobacco | <input type="checkbox"/> | <input type="checkbox"/> |
| Quantity: _____ | | |

Social History

Please indicate hobbies and interest:

| | YES | NO |
|-----------|--------------------------|--------------------------|
| Computers | <input type="checkbox"/> | <input type="checkbox"/> |
| Fishing | <input type="checkbox"/> | <input type="checkbox"/> |
| Golfing | <input type="checkbox"/> | <input type="checkbox"/> |
| Hunting | <input type="checkbox"/> | <input type="checkbox"/> |
| Music | <input type="checkbox"/> | <input type="checkbox"/> |
| Reading | <input type="checkbox"/> | <input type="checkbox"/> |

REVIEW OF SYSTEMS

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

| EYES | YES | NO | UNKNOWN | GASTROINTESTINAL (Stomach) | YES | NO | UNKNOWN |
|--------------------------------|--------------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|--------------------------|
| Blurred Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cataracts | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crossed Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | GENITOURINARY | | | |
| Distorted Vision (Halos) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chlamydia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gonorrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dryness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Excess Tearing/Watering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Syphilis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye Pain or Soreness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | INTEGUMENTARY (Skin) | | | |
| Flashes/Floaters in Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eczema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Foreign Body Sensation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Glare/Light Sensitivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | LYMPHATIC/HEMATOLOGIC | | | |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | AIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Infection of Eye or Lid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Itching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Bleeding Disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lazy Eye | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mucous Discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Redness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Retinal Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | NEUROLOGIC | | | |
| Sandy or Gritty Feeling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Styes or Chalazion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| BONE/JOINT/MUSCLE | | | | Migraines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint/Muscle Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Polio | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | PSYCHIATRIC | | | |
| CANCER | | | | Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Breast | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lung | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | REPRODUCTIVE | | | |
| Prostate | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nursing Mother | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Skin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CONSTITUTIONAL | | | | RESPIRATORY | | | |
| Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Weight Gain/Loss (Sudden) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ENDOCRINE | | | | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Abnormalities | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| EAR, NOSE, AND THROAT | | | | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | VASCULAR | | | |
| Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dry Mouth/Throat | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Runny Nose | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Cholesterol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus Congestion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

FOR DOCTOR'S USE:

Reviewed: ___/___/___ RC LP SC GM

Reviewed: ___/___/___ RC LP SC GM

Reviewed: ___/___/___ RC LP SC GM

Reviewed: ___/___/___ RC LP SC GM

Reviewed: ___/___/___ RC LP SC GM

Reviewed: ___/___/___ RC LP SC GM

Reviewed: ___/___/___ RC LP SC GM

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