

Welcome to Huddleston and Shepherd Family Vision Care

PLEASE COMPLETE BOTH SIDES OF THIS QUESTIONNAIRE IN BLACK INK.

Step 1	PATIENT REGISTRATION
Patient	_____
Address	_____

City	State Zip
Home phone number	_____
Work phone number	_____
Cell Phone number	_____
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate _____
Social Security number	_____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	
Occupation	_____
Employer	_____
Employer Phone	_____
Spouse's Name	_____
Birthdate	_____ SS# _____
Occupation	_____
Spouse's Employer	_____
IN CASE OF EMERGENCY, CONTACT	
Name	_____
Relationship	_____
Phone number	H _____ W _____
Who may we thank for referring you	_____

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 Huddleston & Shepherd Family Vision 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 Huddleston & Shepherd Family Vision for services furnished me by Huddleston & Shepherd Family Vision. 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

I understand there will be a \$35 contact lens refitting fee if I choose to change the type of contact lens I wear. _____
Initial Here

HIPPA Acknowledgement of Receipt ---- I acknowledge that I received a copy of Huddleston and Shepherd Family Vision notice of privacy practices. **Patient Signature** _____ **Date** _____

Step 3	MEDICAL HISTORY QUESTIONNAIRE
CURRENT MEDICATIONS	PRIMARY CARE PHYSICIAN INFORMATION
<ul style="list-style-type: none"> ▪ _____ ▪ _____ ▪ _____ ▪ _____ 	Name _____ Address _____ Phone Number _____ FAX _____
Do you have any allergies to medications? <input type="checkbox"/> No <input type="checkbox"/> Yes, list _____	
List all serious illnesses, injuries and surgeries: _____	

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"/>	Diabetes	___	<input type="checkbox"/>
Blindness	___	<input type="checkbox"/>	Glaucoma	___	<input type="checkbox"/>
Cancer	___	<input type="checkbox"/>	Heart Disease	___	<input type="checkbox"/>
Cataracts	___	<input type="checkbox"/>	Hypertension	___	<input type="checkbox"/>
Crossed Eyes	___	<input type="checkbox"/>	Retinal Dz.	___	<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: ___/___/___ MH GS
 Reviewed: ___/___/___ MH GS
 Reviewed: ___/___/___ MH GS

Reviewed: ___/___/___ MH GS
 Reviewed: ___/___/___ MH GS
 Reviewed: ___/___/___ MH GS

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 Reviewed: ___/___/___ MH GS
 Reviewed: ___/___/___ MH GS