

WELCOME

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

Step 1: PATIENT REGISTRATION	Step 2: INSURANCE INFORMATION
<p>Patient _____ Address _____ _____ City State Zip Home Phone # _____ Work Phone # _____ Cell Phone # _____ Sex : <input type="checkbox"/> M <input type="checkbox"/> F Birthdate: _____ SSN # _____ Occupation : _____ Employer: _____ Employer Phone: _____ Spouse's Name _____ Occupation _____ IN CASE OF EMERGENCY, CONTACT Name _____ Relationship _____ Phone H _____ W _____</p>	<p>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</p>
Step 3	MEDICAL HISTORY QUESTIONNAIRE
<p style="text-align: center;">PAST PERSONAL HISTORY</p> <p>CURRENT LIST OF MEDICATIONS</p> <p>• _____ • _____ • _____ • _____ • _____ • _____</p> <p>Allergies/Medication Allergies: _____ _____</p> <p>Primary Care Physician: _____</p> <p>Describe all serious illnesses, injuries, and surgeries, including the eyes:</p> <p>_____ _____ _____ _____</p> <p><input type="checkbox"/> I currently wear glasses <input type="checkbox"/> I currently wear soft contact lenses <input type="checkbox"/> I currently wear RGP (Hard) contact lenses <input type="checkbox"/> My glasses are broken/lost <input type="checkbox"/> My most recent prescription isn't working well for me <input type="checkbox"/> I am interested in contact lenses</p> <p>Email Address: _____ (may be used for important correspondence)</p>	

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 _____	<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 Disease _____	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Health Habits
Check which substances you use and the amount:

	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 interests:

	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	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"/>	GENTOURINARY			
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	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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: ___/___/___ 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 indirectly
- 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: _____