

WELCOME!



Please complete both sides of this form in black ink.

STEP 1: PATIENT REGISTRATION

Patient: _____

Address: _____

_____ City _____ State _____ Zip _____

Phone Numbers:

Home _____

Work _____

Cell _____

Email address: _____

Sex: Male Female Birthdate: _____

Social Security Number: _____

Occupation: _____

Employer: _____

Employer Address: _____

How did you hear about us? _____

Spouse's Name: _____

Spouse's Occupation: _____

IN CASE OF EMERGENCY, CONTACT:

Name: _____

Relationship: _____

Phone #: Home _____ Work _____

STEP 2: INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to patient (if not self) _____

Insurance Company _____

Group #: _____ Birthdate _____ SS# _____

Is patient covered by additional/secondary insurance? Yes No

Policyholder Name _____

Relationship to patient_(if not self) _____

Insurance Company _____

Group #: _____ Birthdate _____ SS# _____

ASSIGNMENT & RELEASE / MEDICARE AUTHORIZATION

I, the undersigned, certify that I or my dependant have insurance coverage with _____, and assign directly to The Bond-Wroten Eye Clinic ("The Clinic") all insurance benefits, if any, otherwise payable to me for services rendered. I understand 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 use of this signature on all insurance submissions. **I also certify that all medical information provided on the front and back of this page is true and accurate to the best of my knowledge.**

If applicable, I request payment of authorized Medicare benefits be made on my behalf to The Clinic for services furnished to me by The Clinic. I authorize any holder of medical information about me to release to the Center for 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 CMS-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. Coinsurance and deductibles are based upon the charge determination of the Medicare carrier.

Beneficiary signature

Date

STEP 3: MEDICAL HISTORY QUESTIONNAIRE

MEDICATIONS

PAST PERSONAL HISTORY

ALLERGIES

Describe all serious illnesses, injuries, and surgeries: _____

PRIMARY CARE PHYSICIAN: _____ Phone #: _____ Fax #: _____

Address: _____

STEP 3: MEDICAL HISTORY QUESTIONNAIRE (cont.)

FAMILY HISTORY

SOCIAL HISTORY

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

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
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"/>	High Blood Press. _____	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes _____	<input type="checkbox"/>	<input type="checkbox"/>	Retinal disease _____	<input type="checkbox"/>	<input type="checkbox"/>

Health Habits
Check which you
use & consumption

	<u>YES</u>	<u>NO</u>
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 any
hobbies/interests:

	<u>YES</u>	<u>NO</u>
Computers _____	<input type="checkbox"/>	<input type="checkbox"/>
Sports _____	<input type="checkbox"/>	<input type="checkbox"/>
Fishing _____	<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

Please check any of the following you are currently experiencing, or have had in the past:

<u>EYES</u>	<u>YES</u>	<u>NO</u>	<u>UNKNOWN</u>	<u>GENITOURINARY</u>	<u>YES</u>	<u>NO</u>	<u>UNKNOWN</u>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision (Halos)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>GASTROINTESTINAL (Stomach)</u>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain/soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>INTEGUMENTARY (Skin)</u>			
Flashes of light in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Floater in vision	<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"/>	<u>LYMPHATIC/HEMATOLOGIC (Blood)</u>			
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection of Eye/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"/>	<u>NEUROLOGIC</u>			
Sandy/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"/>
<u>BONE/JOINT/MUSCLE</u>				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"/>	<u>PSYCHIATRIC</u>			
<u>CANCER</u>				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"/>	<u>REPRODUCTIVE</u>			
Prostate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nursing Mother (current)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant (current)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>CONSTITUTIONAL</u>				<u>RESPIRATORY</u>			
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rapid Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>ENDOCRINE</u>				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"/>
<u>EAR, NOSE, & THROAT</u>				Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<u>VASCULAR</u>			
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 ONLY:

Reviewed: ___/___/___ HB AP DR CW SW Reviewed: ___/___/___ HB AP DR CW SW Reviewed: ___/___/___ HB AP DR CW SW