

Welcome to our Office



Step 1	PATIENT REGISTRATION
Patient _____	
Address _____	

City	State
Zip	
Home phone number _____	
Work phone number _____	
Facebook Address _____	
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 AN EMERGENCY, CONTACT	
Name _____	
Relationship _____	
Phone number	H _____ W _____
Whom may we thank for referring you to our office? _____	

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 Friedrichs Family Eye Center 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 Friedrichs Family Eye Center for services furnished to me by Friedrichs Family Eye 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 _____
Acknowledgement of Privacy Policy	
I acknowledge that I was offered a Copy of the Notice of Privacy Practices for this office.	
Signature	Date _____

Step 3	MEDICAL HISTORY QUESTIONNAIRE
MEDICATIONS	PRIMARY CARE PHYSICIAN INFORMATION
<ul style="list-style-type: none"> ▪ _____ ▪ _____ ▪ _____ 	Name _____ Address _____ Phone Number _____ FAX _____
Drug Allergies	
Describe all serious illnesses, injuries and surgeries:	

I give permission to Friedrichs Family Eye Center Optometry to release my medical information and/or records to the following listed people. List Name and Relationship:	

Signature: _____	Date: _____

Patient Name: _____

Exam Date: _____

FAMILY HISTORY

Please note any family member with the following diseases/conditions: M-mother F-father S-sibling GP-grandparent

SOCIAL HISTORY

Health Habits

Check which substances you use and the consumption.

Social History

Please indicate hobbies and interest:

	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"/>

	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: _____		

	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: ___/___/___ ini: ___

Reviewed: ___/___/___ ini: ___

Reviewed: ___/___/___ ini: ___

Reviewed: ___/___/___ ini: ___

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