Welcome to Huddleston and Shepherd Family Vision Care

email to courtneyg@cookevillevision.com / fax: 931-528-1230 / or Print and bring to the office

Step 1 PATIENT REGISTRATION

ID # If you don't have an ID# call the office 931-526-2022

Address _____

_____

City State Zip

Home phone number _____

Work phone number _____

Cell Phone number _____

Sex ☐ M ☐ F Birthdate _____

Social Security number complete in office _____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation _____

Employer _____

Employer Phone _____

Prefer Contact By ◯ Text ◯ Email ◯ US Mail

Spouse's Name complete in office _____

Spouse 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? Self ☐ Other ☐

Name & Relation to Patient in office

Birthdate _____ SS# in office

Insurance Company _____

Group number in office _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name Self ☐ Other _____

Birthdate in office SS# in office

Relationship to Patient _____

Insurance Company _____

Group number in office _____

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.

in office _____ _____

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.

In office _____ _____

Beneficiary Signature Date

I understand there will be a $38 contact lens evaluation and management fee if I am a contact lens wearer. _____ **Initial Here**

HIPPA Acknowledgement of Receipt and Clinical Summary ---- I acknowledge that a copy of Huddleston and Shepherd Family Vision's **notice of privacy practices** has been made available to me and ,at my request, a **clinical summary** of my examination will be made available to me within three business days. **Patient Signature** in office **Date** _____

Step 3 MEDICAL HISTORY QUESTIONNAIRE

Height	___' ___"	**Weight**	_____lbs

CURRENT MEDICATIONS

- _____ _____
- _____ _____
- _____ _____
- _____ _____

PRIMARY CARE PHYSICIAN INFORMATION

Name _____

Address _____

_____

Phone Number _____ **FAX** _____

Do you have any allergies to medications? ☐ No ☐ Yes, list _____

List all serious illnesses, injuries and surgeries: _____

_____

EMAIL ADDRESS _____ **(By providing an email address, you grant us permission to use it only for the purpose of communicating with you. WE WILL NOT SHARE THIS WITH OUTSIDE SOURCES.)**

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	___	☐	☐	Diabetes	___	☐	☐
Blindness	___	☐	☐	Glaucoma	___	☐	☐
Cancer	___	☐	☐	Heart Disease	__	☐	☐
Cataracts	___	☐	☐	Hypertension	___	☐	☐
Crossed Eyes	__	☐	☐	Retinal Dz.	___	☐	☐

SOCIAL HISTORY

Health Habits

Check which substances you use and the consumption.

	YES	NO
Alcohol	☐	☐
Quantity: _____		
Drugs	☐	☐
Quantity: _____		

Tobacco	YES	NO
Current user	☐	☐
Quantity: _____		
Former user	☐	☐
Years since you stopped _____		

REVIEW OF SYSTEMS

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

EYES	YES	NO	UNKNOWN
Blurred Vision	☐	☐	☐
Burning	☐	☐	☐
Cataracts	☐	☐	☐
Crossed Eyes	☐	☐	☐
Distorted Vision (Halos)	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Flashes/Floaters in Vision	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Glaucoma	☐	☐	☐
Infection of Eye or Lid	☐	☐	☐
Itching	☐	☐	☐
Lazy Eye	☐	☐	☐
Loss of Vision	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Retinal Disease	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Styes or Chalazion	☐	☐	☐
BONE/JOINT/MUSCLE			
Arthritis	☐	☐	☐
Joint/Muscle Pain	☐	☐	☐
Polio	☐	☐	☐
VASCULAR			
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Stroke	☐	☐	☐
CONSTITUTIONAL			
Fever	☐	☐	☐
Weight Gain/Loss (Sudden)	☐	☐	☐
ENDOCRINE			
Diabetes	☐	☐	☐
Thyroid Abnormalities	☐	☐	☐
EAR, NOSE, AND THROAT			
Allergies	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Mouth/Throat	☐	☐	☐
Runny Nose	☐	☐	☐
Sinus Congestion	☐	☐	☐

GASTROINTESTINAL (Stomach)	YES	NO	UNKNOWN
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Ulcers	☐	☐	☐
GENITOURINARY			
Chlamydia	☐	☐	☐
Gonorrhea	☐	☐	☐
Kidney Disease	☐	☐	☐
Syphilis	☐	☐	☐
INTEGUMENTARY (Skin)			
Eczema	☐	☐	☐
Psoriasis	☐	☐	☐
LYMPHATIC/HEMATOLOGIC			
AIDS	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Disorders	☐	☐	☐
Hepatitis	☐	☐	☐
Herpes	☐	☐	☐
HIV Positive	☐	☐	☐
Liver Disease	☐	☐	☐
NEUROLOGIC			
Epilepsy	☐	☐	☐
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Seizures	☐	☐	☐
PSYCHIATRIC			
Depression	☐	☐	☐
High Anxiety	☐	☐	☐
REPRODUCTIVE			
Nursing Mother	☐	☐	☐
Pregnant	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
Pneumonia	☐	☐	☐
Tuberculosis	☐	☐	☐

FOR DOCTOR'S USE:

Reviewed: ____/____/____ JC / ES / GS **Reviewed: ____/____/____ JC / ES / GS** **Reviewed: ____/____/____ JC / ES / GS**

Reviewed: ____/____/____ JC / ES / GS **Reviewed: ____/____/____ JC / ES / GS** **Reviewed: ____/____/____ JC / ES / GS**

Reviewed: ____/____/____ JC / ES / GS **Reviewed: ____/____/____ JC / ES / GS** **Reviewed: ____/____/____ JC / ES / GS**