# MEDICAL / INSURANCE IN-TAKE

**Date of Service;** ______/______/______.

***Patient* Name;** (Last)____________________, (First)____________________.

***Patient* Date of Birth;** (mm)______/(dd)______/(yyyy)______. **Sex;** Male ☐ Female ☐

***Insured's* Name;** (Last)____________________, (First)________________, (Middle Initial)________.

***Patient* Address;** No., Street____________________, City________________, State__________, Zip__________.

***Patient* Telephone** (Home) (   )    -    , (Work) (   )    -    , (Cell) (   )    -    .

***Patient* Relationship to Insured;** self ☐ spouse ☐ child ☐ other ☐

***Insured's* Address;** same as above ☐

No., Street ____________________, City____________________, State__________, Zip__________.

***Patient* Status;** Single ☐ Married ☐ Other ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐

***Insureds* Date of Birth;** (mm)______/(dd)______/(yyyy)______. **Sex;** male ☐ female ☐

**Insurance Plan Name or Program Name;** ________________________________.

**Prior Authorization Number** (*office personel only*)________________________________.

## *Secondary* Insurance Information

***Other* Insureds Name** (Last)____________________, (First)____________________, (middle initial)__________.

***Other* Insureds Policy or Group Number;** ________________________________.

***Other* Insureds Date of Birth;** (mm)__________/(dd)__________/(yyyy)__________.

**Insurance Plan Name or Program Name;** ________________________________.

**Is Patient Condition Related to;** Employment ☐ yes ☐ no Auto Accident ☐ yes ☐ no Other Accident ☐ yes ☐ no

## *Insurance Assignment and Release* *Signature on File*

I certify that I, and/or my dependent(s), have insurance coverage and assign directly to the offices of Dr. Richard Bohn, Optometrist, all insurance benefits, if any, otherwise payable for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The office of Dr. Richard Bohn, Optometrist, may use my health care information and may disclose such information to the respective Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Patient Signature or Legal Guardian **X**________________________________. Date ______/______/______.

Please Print Name ________________________________. Relationship to patient ____________________.

*****Signature on file will also serve as authorization for telephone order credit card purchases*****

Today's Date: ______________

# PATIENT HISTORY QUESTIONNAIRE

**IMPORTANT: This questionnaire is to be reviewed at each appointment. Please answer all questions.**

Last Name ______________ First Name ______________ MI ______
Address ______________ City ______________ State ________ Zip ______
Work Phone ______________ Home Phone ______________
Date of birth ______________ Occupation ______________ Employer ______________
Emergency Contact Name ______________ Phone Number ______________
Date of Last Eye Exam ______________ Dilated? Yes / No Referred By: ______________
Primary Medical Coverage ______________ Vision Coverage ______________

## Medical Information

What is your general health? ______________

Do you have problems with any of these systems? **(Please circle yes or no.)**

| | | | | | |
|---|---|---|---|---|---|
| Gastrointestinal | Yes/No | Nervous | Yes/No | Endocrine (glands) | Yes/No |
| Ears/Nose/Throat | Yes/No | Urinary | Yes/No | Blood/Lymph | Yes/No |
| Cardiovascular | Yes/No | Muscles/Bones | Yes/No | Allergic/Immunologic | Yes/No |
| Respiratory | Yes/No | Integumentary (skin) | Yes/No | Headaches | Yes/No |
| High Blood Pressure | Yes/No | Eyes | Yes/No | Mental | Yes/No |

Please explain ______________

Diabetes Yes/No Type ______________ Date of diagnosis ______________
Allergies to Medication Yes/No Which? ______________ Reactions? ______________
Other health problems ______________
Current medication(s) ______________
Have you had any operations? Yes/No Kind? ______________ When? ______________
Name of family doctor ______________
Date of last visit ______________ Date of last tetanus shot ______________

## Family History

| | | | | | |
|---|---|---|---|---|---|
| High blood pressure | Yes/No | Relation ______ | Macular degeneration | Yes/No | Relation ______ |
| Diabetes | Yes/No | Relation ______ | Retinal detachment | Yes/No | Relation ______ |
| Glaucoma | Yes/No | Relation ______ | Cataracts | Yes/No | Relation ______ |

## Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? ______________
Have you had any eye operations? Yes/No Type ______________ Date ______________
Have you had an eye injury? Yes/No Kind ______________ Date ______________

| | | | | | |
|---|---|---|---|---|---|
| Do you have glaucoma? | Yes/No | Cataracts? | Yes/No | Dry eyes? | Yes/No |
| Macular degeneration? | Yes/No | Retinal detachment? | Yes/No | Blurred vision? | Yes/No |
| Do you wear glasses? | Yes/No | Contact lenses? | Yes/No | Type ______ | |

Additional information ______________

## Doctor Use Only

Reviewed by ______________ ☐ No changes Date ______________
Reviewed by ______________ ☐ No changes Date ______________
Reviewed by ______________ ☐ No changes Date ______________