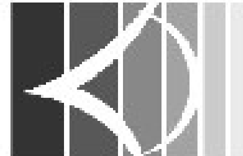
PATIENT INFORMATION



SPECTRUM EYE CARE

HEALTH • VISION • OPTICAL

GENERAL INFORMATION

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Home Phone ______________ Cell/Other Phone ______________ E-mail ______________________

Preferred form of contact: ☐ Home phone ☐ Cell Phone ☐ Work Phone ☐ E-mail

☐ Male ☐ Female Birthdate ____/____/____ Age ________ ☐Single ☐Married ☐Widowed ☐Other

Employer ______________________________ Occupation ______________________________

EMERGENCY CONTACT INFORMATION

Name ____________________ Relationship ______________ Home Phone ____________________

Referred by ____________________or ☐ Phone Book ☐ Facebook ☐ Insurance ☐ Website

RESPONSIBLE PARTY INFORMATION

Person responsible for Account ____

Relationship to Patient ______________ Birthdate ____/____/____ Social Security # _____-____-______

Address ______________________________ City, State, Zip ______________________

Employer of Person Responsible ______________________ Business Phone ______________
(if different than patient)

INSURANCE INFORMATION

Do you have insurance? ☐ Yes ☐ No

Insurance Company ____________________ ID # ______________ Group # ______________

Address ______________________________________ Phone ____________________

Secondary Insurance ____________________ ID # ______________ Group # ______________

Address ______________________________________ Phone ____________________

AUTHORIZATION TO PAY BENEFITS TO PROVIDER

I hereby authorize payment directly to all providers of the medical benefits, if any, otherwise payable to me for services rendered by Dr. Ryan Orgill, O.D. I understand that I am responsible for any charges incurred by me or any party for whom I am legally responsible. I also agree that in the case of default of payment I will be responsible for any cost incurred in the collection of such account, including reasonable attorney fees and court costs. I hereby waive notice of dishonor, demand, and protest. All exemptions are waived.

I, the undersigned, hereby acknowledge that it is the policy of this office that full payment be made at each visit, and I am responsible for payment to Dr. Ryan Orgill for all serves rendered the above patient that are not covered by Medicare assignment, Medicaid, Workman's Compensation, or other benefits agreed by the provider of such services. I certify that the information contained herein is complete and correct. I authorize photocopies of this form to be valid as the original.

Signature of Patient or Guardian ______________________________ Date ______________

RELEASE OF MEDICAL RECORDS AND INFORMATION

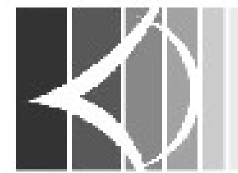
To: Custodian of Medical Records

This authorizes you to release to Spectrum Eye Care, 225 E. Main St. STE. E, Grantsville, UT 84029, full and complete medical records, reports, evaluations, consultations or information (collectively referred to as "medical records" you may have in custody concerning the undersigned patient. The undersigned represents and warrants that he/she has full authority to request said records and to agree to all of the conditions recited herein. The undersigned expressly releases and forever discharges and agrees to indemnify and hold harmless Spectrum Eye Care, including its owner and employees, from any and all claims, damages, actions, causes of action or suits of any kind or nature whatsoever arising out of or from the release of any medical records pursuant to this authorization.

Signature of Patient or Guardian ______________________________ Date ______________

I acknowledge that I have viewed and been offerered a copy of the privacy policy for Spectrum Eye Care. ______________
Please Initial

MEDICAL QUESTIONNAIRE



SPECTRUM EYE CARE
HEALTH • VISION • OPTICAL

Name ______________________________

Today's Date ____ / ____ / ____

Date of last medical exam ____ / ____ (month/day)

Date of last eye exam ____ / ____ (month/day)

Primary Care Physician ______________________________

MEDICAL HISTORY

List any known allergies to medications or other substances: ______________________________

List any medications you are currently taking (prescription or otherwise): ______________________________

____

Have you recently been hospitalized or had surgery? ☐ YES ☐ NO If so, please indicate why:

____

REVIEW OF SYMPTOMS Do you currently, or have you EVER had any problems in the following areas:

	YES	NO
VISION		
Loss of vision	☐	☐
Blurred vision	☐	☐
Double vision	☐	☐
Eye injury	☐	☐
Eye surgery	☐	☐
Floaters/Flashes	☐	☐
Glare/Halos	☐	☐
Crossed or lazy eye	☐	☐
Cataracts	☐	☐
Glaucoma	☐	☐
Eye pain or soreness	☐	☐
Retinal disease	☐	☐
ENDOCRINE		
Thyroid	☐	☐
Diabetes	☐	☐
BONES/JOINTS/MUSCLES		
Rheumatoid arthritis	☐	☐
Joint pain	☐	☐
VASCULAR/HEART		
High blood pressure	☐	☐
Heart pain	☐	☐

	YES	NO
HEMATOLOGIC		
Anemia	☐	☐
NEUROLOGICAL		
Headaches	☐	☐
Migraines	☐	☐
Seizures	☐	☐
RESPIRATORY		
Asthma	☐	☐
Chronic bronchitis	☐	☐
Emphysema	☐	☐
SKIN		
Acne	☐	☐
PSYCHIATRIC	☐	☐
GASTROINTESTINAL		
Crohn's	☐	☐
EAR/NOSE/THROAT/MOUTH		
Allergies/Hay Fever	☐	☐
GENITOURINARY		
Kidney/Bladder/Genital	☐	☐

If you answered YES to any of the above, please explain:

____

____

SOCIAL HISTORY

Do you use tobacco products? ☐ YES ☐ NO

Do you use illicit drugs? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

Have you been exposed to or infected with:
(please circle any that apply)
Gonorrhea Hepatitis HIV Syphilis

FAMILY HISTORY

Please list any family history (parents, grandparents, siblings, and/or children - living or deceased) for the following:

OCULAR CONDITION		
Blindness	☐ YES	☐ NO
Crossed Eyes	☐ YES	☐ NO
Glaucoma	☐ YES	☐ NO
Macular degeneration	☐ YES	☐ NO
Retinal detachment	☐ YES	☐ NO

SYSTEMIC CONDITION		
Diabetes	☐ YES	☐ NO
High blood pressure	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO

By signing this form, I consent to treatment for myself and/or on behalf of the Minor for which this information pertains. I give permission for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate. I further attest that I am the Parent or Legal Guardian for Minor and have the authority to authorize care and treatment.

____
Signature Date