

Welcome to Parker Vision Specialists, P.C.

Appointment Date: _____, 20____ :____ m

<u>title</u> <u>first name</u> <u>middle name or initial</u> <u>last name</u>		<u>preferred name</u>	<u>if patient is a child, parent's name</u>
<u>mailing address</u> (street, city, state, zipcode)		<input type="checkbox"/> male <input type="checkbox"/> female	<u>parent's address, if different from at left</u>
		<u>date of birth</u> (mm/dd/yy) / /	
I prefer you contact me <input type="checkbox"/> by postal mail at the address shown above <input type="checkbox"/> by day phone: () - <input type="checkbox"/> by home phone: () - <input type="checkbox"/> by my email: @ <input type="checkbox"/> by other means:		<u>if patient is a student, circle which grade</u> Preschool K 1 2 3 4 5 6 7 8 9 10 11 12 school: teacher:	
<u>social security #</u>	<u>significant other</u>		How Did You Choose Us? <input type="checkbox"/> Our Web Site <input type="checkbox"/> Yellow Pages <input type="checkbox"/> Insurance Booklet <input type="checkbox"/> Family Has Been In <input type="checkbox"/> Primary Care Doctor <input type="checkbox"/> Eye Specialist Doctor <input type="checkbox"/> In Building, Stopped By <input type="checkbox"/> Lecture/Health Fair <input type="checkbox"/> Referred by Patient <input type="checkbox"/> Other
<u>employer & work address</u>	<u>emergency contact name, phone, email</u>		
<u>vision insurance name & address</u>	<u>insured name</u>		
<u>group #</u>	<u>ID #</u>		
<u>medical insurance name & address</u>	<u>insured name</u>		
<u>group #</u>	<u>ID #</u>		
<u>financially responsible party</u>	I authorize the release of any medical or other information necessary to process insurance claims. I also request payment of government benefits to myself or the party who accepts assignment above. signed: _____ print name: _____	I authorize payment of medical benefits to the above listed physician or supplier for services rendered. signed: _____ print name: _____	
<u>payment preference</u> <input type="checkbox"/> Insurance <input type="checkbox"/> Check <input type="checkbox"/> Charge Card <input type="checkbox"/> Cash Payment is expected at the time services are rendered, including non-covered portions of insurance.			
<u>family physician name & address</u>	Internal Use Only Acct. #: _____ FD Initials: _____ Waivers Signed (ABN, Finance, HIPPA)? Y N Time: _____ Photograph Taken? Y N Copies of Insurance? Y N Address/Phone Number/email Verified? Y N		

Parker Vision Specialists, P.C. patient info form: Medical History of _____ page 2 of 2

Date of last eye exam: _____ Previous Eye Doctor: _____

Current occupation: _____ Hours per day using a computer: _____

Hobbies/Sports: _____

Are you interested in Laser Refractive Surgery? Y / N

Are you interested in Corneal Refractive Therapy or contact lenses? Y / N

Have you ever worn contacts? Y / N Reasons for stopping? _____

Do you currently wear contacts? Y / N How many hours per day? _____ How many days per week? _____

Do you currently wear glasses? Y / N _____ Full time _____ Distance only _____ Near only _____ Bifocal _____ Computer

How old are your current prescriptions for contacts? _____ Glasses? _____ Do you wear sunglasses? Y / N

Please mark any of the following symptoms you experience:

____ Decreased distance vision ____ Headaches ____ Redness ____ Dry Eyes

____ Decreased near vision ____ Glare while driving ____ Itchy eyes ____ Irritation/Burning

____ Decreased night vision ____ Eyestrain ____ Watery eyes ____ Hay fever

____ Decreased side vision ____ Floaters ____ Double vision ____ Flashes of light

____ Light sensitivity Other symptoms: _____

Current medications, vitamins and/or herbal supplements: _____

Allergies to medications: _____

Eye History:

	Self	Blood relative and Whom?
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Amblyopia (Lazy Eye)..... Y / N..... Y / N _____

Macular degeneration..... Y / N..... Y / N _____

Retinal detachment..... Y / N..... Y / N _____

Strabismus..... Y / N..... Y / N _____

Glaucoma..... Y / N..... Y / N _____

Blindness..... Y / N..... Y / N _____

Cataracts..... Y / N..... Y / N _____

Color Blindness..... Y / N..... Y / N _____

Have you had vision therapy? Y / N When? _____ If yes, what for? _____

Have you had an eye injury or surgery? Y / N If yes, for what? _____

Medical History:

	Self	Blood relative and Whom?
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Psychiatric (example: depression)..... Y / N..... Y / N _____

Allergies/Immunologic (hayfever, lupus)..... Y / N..... Y / N _____

Cardiovascular (high blood pressure, cholesterol)..... Y / N..... Y / N _____

Respiratory (asthma, COPD)..... Y / N..... Y / N _____

Neurological (stroke, M.S., migraines)..... Y / N..... Y / N _____

Musculoskeletal (arthritis, fibromyalgia)..... Y / N..... Y / N _____

Integumentary (acne or skin disorders)..... Y / N..... Y / N _____

Endocrine (diabetes, thyroid)..... Y / N..... Y / N _____

Gastrointestinal (Crohn's, IBS, acid reflux)..... Y / N..... Y / N _____

How is you general health? (Please circle) Good Fair Poor

Other (for example: cancer, kidney, liver, HIV, TB): _____

Do you use tobacco? Y / N Have you in the past smoked? Y / N When? _____

Do you use recreational drugs? Y / N

Do you use alcohol? Y / N For doctor only: Dr. Sig _____

Are you or could you be pregnant? Y / N How many weeks? _____ For office only: Tech ID _____