PATIENT INFORMATION

DEMOGRAPHICS

NAME LAST FIRST MI				BIRTH DATE
STREET ADDRESS				SOCIAL SECURITY #
CITY	STATE	ZIP CODE	GENDER	BEST PHONE NUMBER

OCCUPATION	EMAIL	EMERGENCY CONTACT NAME	EMERGENCY PHONE

BILLING

PRIMARY INSURANCE POLICY HOLDER NAME	BIRTH DATE	RELATIONSHIP TO PATIENT (CIRCLE ONE) SELF SPOUSE PARENT OTHER

FOR MINORS (UNDER THE AGE OF 18)

FINANCIALLY RESPONSIBLE PARTY NAME		PHONE NUMBER	
STREET ADDRESS	CITY	STATE	ZIP CODE

I understand and acknowledge all of the following:

- The Eye Center of Parkville follows HIPAA laws that protect your personal health information. I have been offered a copy of the Notice of Privacy Practices (HIPAA).
- I authorize The Eye Center of Parkville to bill my insurance company and receive payments. I understand I am financially responsible for all copays, deductibles and coinsurance amounts. I also authorize The Eye Center of Parkville to release any information needed for the processing of my claim.
- I understand that payment for all optometric professional services is due at the time of service.
- I understand that payment for eye glasses and contact lenses is due at the time of ordering.
- I consent to a detailed message left on voicemail: ☐ YES ☐ NO
- I would like to receive my appointment reminders by: ☐ TEXT ☐ EMAIL

_____ _____

Patient/Parent/Guardian Signature Date

HEALTH HISTORY

Yes No

- ☐ ☐ Asthma _____
- ☐ ☐ Kidney Disease _____
- ☐ ☐ Tuberculosis _____
- ☐ ☐ Diabetes _____
- ☐ ☐ Migraines _____
- ☐ ☐ Psychiatric Disorder _____
- ☐ ☐ Nervous Disorder _____
- ☐ ☐ Heart Disease _____
- ☐ ☐ Ulcer _____
- ☐ ☐ High Blood Pressure_____
- ☐ ☐ Do you smoke?_____
- ☐ ☐ Do you drink? _____
- ☐ ☐ Taken any illegal substances within the last 12 months?

Yes No

- ☐ ☐ Head or Spinal injuries _____
- ☐ ☐ Seizures, Convulsions, or Fainting _____
- ☐ ☐ Temporal Arteritis _____
- ☐ ☐ Carotid Artery Disease _____
- ☐ ☐ Stroke _____
- ☐ ☐ HIV _____
- ☐ ☐ Liver Disease _____
- ☐ ☐ Rheumatoid Arthritis _____
- ☐ ☐ Cancer _____
- ☐ ☐ Sickle Cell Anemia_____
- ☐ ☐ Other Diagnosed Health Problems_____

_____

Please list all Medications you are **currently taking**:

_____

_____

_____

_____

_____

Please list all Medications you are **allergic** to:

_____

_____

_____

_____

_____

YOUR OCULAR HISTORY

Yes No

- ☐ ☐ Cataracts
- ☐ ☐ Glaucoma
- ☐ ☐ Corneal Disease
- ☐ ☐ Retinal Disease

Yes No

- ☐ ☐ Cataract Surgery
- ☐ ☐ Glaucoma Surgery
- ☐ ☐ Corneal Surgery
- ☐ ☐ Retinal Surgery

Yes No

- ☐ ☐ Crossed eyes / Lazy eye
- ☐ ☐ Iritis / Uveitis
- ☐ ☐ Eye Muscle Surgery
- ☐ ☐ Other: _____

OCULAR FAMILY HISTORY

Yes No

- ☐ ☐ Cataracts
- ☐ ☐ Glaucoma
- ☐ ☐ Corneal Disease

Yes No

- ☐ ☐ Macular Degeneration
- ☐ ☐ Retinitis Pigmentosa
- ☐ ☐ Retinal Detachment

SURGICAL HISTORY (please include date & type)

_____

_____

_____

_____