Welcome to our Office!

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Daytime/Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 digits of your SSN: \_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vision Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Holders Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary’s Date of Birth: \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_ Last 4 of their SSN: \_\_\_\_\_\_\_\_\_\_\_

Medical Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently wear glasses? Yes No Do you currently wear contacts? Yes No

**History**: Check any conditions that pertain to you now or in the past:

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_ Asthma | \_\_\_ Eye Surgery | \_\_\_ Headaches/Migraines | \_\_\_ MS |
| \_\_\_ Blurred Vision | \_\_\_ Diabetes  | \_\_\_ Heart Disease | \_\_\_ Retinal Disease |
| \_\_\_ Cataract  | \_\_\_ Double Vision | \_\_\_ Hypertension | \_\_\_ Thyroid |
| \_\_\_ Eye Infection | \_\_\_ Floaters | \_\_\_ Loss of Vision | \_\_\_ Crossed/Lazy Eye |
| \_\_\_ Eye Injury  | \_\_\_ Glaucoma | \_\_\_ Macular Degeneration |  |

**Family History**: Check any conditions that family members have now or have had in the past:

\_\_\_ Glaucoma \_\_\_ Blindness \_\_\_ Diabetes \_\_\_ Macular Degeneration

**Medications**: Please list all medications you are currently taking: *(Or provide a separate list)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Are you allergic to any medications?* Y / N - If so, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HIPAA Privacy Policy**

I acknowledge that I have viewed the Notice of Privacy Practices for the doctors of Parker Optical PLLC.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**Authorization to Release Identifying Medical Records**

I authorize Parker Optical PLLC to release health information identifying me, including but not limited to prescriptions, exam history, invoices and exam history & notations via email, fax, or mail at my request.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_