Welcome to

Parker Optical

Earl S. Voight, O.D.

Taffy J. Whiteman, O.D.

--- Thank you for choosing our practice for your eye care needs ---

If you have VISION INSURANCE please fill out the insurance information SSN is used for Ins. Purposes

Insurance Name: ______________________________ Member ID#: __________________________

Member Name: ______________________________ Member Date of Birth: __________________

Employer of Member: ____

Patient Information

Date: ______________ Name: ____ Sex: M F

Last First MI

Marital Status: ___________ Spouse Name: ____

Date of Birth: ______________ Age: _____________ Social Security #: _____________________

Address: _____________________ City: ________________ State: ______ Zip: ______________

Home Phone: _________________ Business &/or Cell Phone: ______________________________

Do you prefer to receive calls at_______ home____ work______ either

Occupation: ______________________ Employer's Name: ___________________________________

Reason for today's visit: ____

Are you presently being treated for any illness? Y N What medications? _______________

Over the counter Medication Use? Y N If yes what? ________________________ Smoker? Y N

Allergic to any Medication? Y N If yes what? ____

Alcohol Use? Y N

Family History: Cataracts Y N Macular Degeneration Y N Glaucoma Y N

Diabetes Y N Heart Disease Y N

Are you pregnant and/or nursing Y N _______________

Name & Phone Number of family Physician ____

Your Signature ____

(or parent's signature if a minor)

Parent Information: (if patient is a dependent)

Name: ___________________________ Relationship to Patient: ___________________ Sex: M F

Address: _________________________ City: _______________ State: _______ Zip: __________

(If different than address above)

Home Phone: ____________________ Business &/or Cell Phone: ____________________________