Robert J. Parks O.D
Welcome Back To Our Office

Welcome to Robert J. Parks O.D. Thank you for choosing us for your eyecare needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all completed areas to ensure that the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Male ☐ Female

First Name | MI | Last Name | Preferred Name

Street Address | City | State Zip

Date of Birth | Home Phone - Include Area Code | Day Phone

Email Address | Guardian | Person Responsible for Account

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient
☐ Insurance Listing ☐ Drive by ☐ Other ☐ Doctor

Who were you referred by? _____

PRIMARY INSURANCE INFORMATION ☐ VSP ☐ Eyemed

Name and Address of Primary Insurance Company | City | State Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

SECONDARY INSURANCE INFORMATION

Name and Address of Secondary Insurance Company | City | State Zip

M ☐ F ☐ Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship to Insured
☐ Self ☐ Spouse ☐ Child ☐ Other

Please Read:

We ask that the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. All professional services and material are charged to the patient. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Accounts 90 days old are subject to collection fees. There will be a service charge on all returned checks.

Payment from my insurance is to be paid directly to Robert J. Parks, O.D.. I understand that my primary insurance will be billed. I understand that billing any secondary insurance is my responsibility. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed.

I understand my rights regarding my medical records. A copy of Robert J. Parks, O.D. Notice of Privacy Practices has been made available to me. P.P. Update 2013

Signature | Date

Name

Robert J. Parks O.D
PATIENT HISTORY AND INFORMATION

Race

☐ American Indian Or Alaska Native ☐ Other Race ☐ Refuse To Specify
☐ Asian ☐ Not Disclosed
☐ Black Or African American ☐ Native American
☐ Native Hawaiian Or Other Pacific Islander ☐ Caucasian

Other Race

Ethnicity ○ Hispanic Or Latino ○ Not Hispanic Or Latino ○ Unknown

Preferred Language ○ English ○ Spanish ○ French ○ Italian ○ Russian ○ Portuguese

Height ft [ ] in [ ] cm/m [ ] ◉ ft in ○ cm ○ m **Weight** [ ] ◉ lbs ○ kg

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? When was your last exam ?

When was your last health exam ?

Past Illnesses or Injuries:

Past Surgeries:

Current Medications:

Current Eye Drops:

Specific Allergies:

Allergy Reaction:

EYE HISTORY

Glaucoma	○ Yes ○ No	Dryness	○ Yes ○ No	Strabismus (Crossed Eyes)	○ Yes ○ No
Cataract	○ Yes ○ No	Excess Tearing/Watering	○ Yes ○ No	Blurred Vision Distance	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Eye Pain or Soreness	○ Yes ○ No	Blurred Vision Near	○ Yes ○ No
Retinal Detachment	○ Yes ○ No	Foreign Body Sensation	○ Yes ○ No	Distorted Vision (halos)	○ Yes ○ No
Color Blindness	○ Yes ○ No	Infection of Eye or Lid	○ Yes ○ No	Double Vision	○ Yes ○ No
Headaches	○ Yes ○ No	Itching	○ Yes ○ No	Floaters or Spots	○ Yes ○ No
Glare/Light Sensitivity	○ Yes ○ No	Mucous Discharge	○ Yes ○ No	Fluctuating Vision	○ Yes ○ No
Tired Eyes	○ Yes ○ No	Drooping Eyelid	○ Yes ○ No	Loss of Vision	○ Yes ○ No
Amblyopia (Lazy Eye)	○ Yes ○ No	Redness	○ Yes ○ No	Loss of Side Vision	○ Yes ○ No
Burning	○ Yes ○ No	Sandy or Gritty Feeling	○ Yes ○ No		

GENERAL HEALTH CONDITION

Fever	○ Yes ○ No	Respiratory (Asthma)	○ Yes ○ No	Anxiety or Depression	○ Yes ○ No
Weight Loss	○ Yes ○ No	Gastrointestinal	○ Yes ○ No	Thyroid, Diabetes	○ Yes ○ No
Other Symptoms	○ Yes ○ No	Kidney	○ Yes ○ No	Blood/Lymph	○ Yes ○ No
Ears,Nose,Throat	○ Yes ○ No	Muscles,Bones,Joints	○ Yes ○ No	Allergic	○ Yes ○ No
Cardiovascular (high blood pressure etc.)	○ Yes ○ No	Skin	○ Yes ○ No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	○ Yes ○ No		

Name _____

Robert J. Parks O.D

MEDICAL HISTORY QUESTIONAIRE

FAMILY HISTORY

Amblyopia (Lazy Eye)	○ Yes ○ No	Retinal Detachment	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Blindness	○ Yes ○ No	Strabismus (Eye Turn)	○ Yes ○ No	Kidney Disease	○ Yes ○ No
Cataract(s)	○ Yes ○ No	Arthritis	○ Yes ○ No	Lupus	○ Yes ○ No
Color Blindness	○ Yes ○ No	Cancer	○ Yes ○ No	Stroke	○ Yes ○ No
Glaucoma	○ Yes ○ No	Diabetes	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Macular Degeneration	○ Yes ○ No	Heart Disease	○ Yes ○ No	Others	○ Yes ○ No

SPECTACLE LENS HISTORY

Do you use a computer? ○ Yes ○ No

Do you have glare problems? ○ Yes ○ No

Do you currently wear glasses ? ○ Yes ○ No

Do you have visual difficulty when driving? ○ Yes ○ No

Do you have problems with night vision? ○ Yes ○ No

Glasses Owned ☐ SingleVision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Have you had trouble in the past with glasses? ○ Yes ○ No _____

Do you wear sunglasses? ○ Yes ○ No

Are your sun glasses your current prescription ? ○ Yes ○ No

SPECIAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special anti-glare tints or coatings)

☐ Occupational (mechanics, plumbers, pilots)

☐ Safety Glasses (gardening, woodworking, welding)

☐ Sports/Hobbies (racquet sports, motorcycle)

CONTACT LENS HISTORY

If not a contact lens wearer, are you interested in trying contact lenses at this time ? ○ Yes ○ No

Have you ever tried to wear contact lenses? ○ Yes ○ No Reason for stopping? _____

Do you currently wear contact lenses? ○ Yes ○ No Since _____

Type and brand of contact lenses _____ Today's wearing time ? _____

How many hours/day ? _____ How many days/week ? _____

What Solutions do you use? _____

SOCIAL HISTORY

Current Occupation : _____

Do you use nutritional supplements (vitamins etc.)? ○ Yes ○ No

Do you drink alcohol ? If yes, how much/often : ○ No ○ Occasional ○ 1 Per Day ○ 2-3/day ○ 4+/day

Do you smoke ? If yes, how much/often : ○ No ○ Occasional ○ 1/2 pack/day ○ 1 pack/day ○ 1+ pack

Method of Tobacco Intake : ○ Smoking ○ Chewing