PARKWAY VISION

PATIENT REGISTRATION FORM

Today's date:

PATIENT INFORMATION

First Name:	Middle:	Last:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Birth date: / /	Age:	Sex: ❑ M ❑ F	Social Security Number: - -

Street address:	City:	State:	ZIP Code:

Mobile Phone: ( )	Other Phone: ( )	Email Address:

Occupation:	Employer:

How did you hear about us? (please check one box):

❑ Family ❑ Friend ❑ Insurance ❑ Web search ❑ Other _____

Other family members seen here:

INSURANCE

Vision Insurance:	Medical Insurance:

Primary Name (on card):	Primary Date of Birth / /	Primary Insurance ID or Social Security Number

Primary Employer	Relationship to Primary

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone #: ( )

FINANCIAL RESPONSIBILITY

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance not paid by my insurance. I also authorize PARKWAY VISION or insurance company to release any information required to process my claims.

- All professional fees are due and payable at the time of service
- Fees paid for any services are NON-REFUNDABLE
- There will be no fee for follow up visits on glasses or contact lens fittings within 60 days of the initial comprehensive exam.
- <u>There will be a refraction fee for any follow ups on glasses or contacts past 60 days</u>

_____ _____

Patient/Guardian signature *Date*

NOTICE OF PRIVACY PRACTICES

A "Notice of Privacy Practices" that describes how my protected health information is used and disclosed has been made available to me. I understand I may request a printed copy at anytime.

_____ _____

Patient/Guardian signature *Date*

PATIENT HISTORY

Reason For Visit: ❑ Blurry Distance Vision ❑ Blurry Near Vision ❑ Other _____

How long ago was your last eye exam?

Do you wear: ❑ Glasses ❑ Contact lenses | Are you interested in in contact lenses? ❑YES ❑ NO

Are you interested in refractive surgery (LASIK)? ❑ YES ❑ NO

List any medications (including eye drops) that you are currently taking:

List any allergies to medications, food or other substances:

PLEASE CHECK ALL THAT APPLY:

Medical History		Ocular History			*FAMILY HISTORY*	
Diabetes		Glaucoma			*Diabetes*	
High Blood Pressure		Macular Degeneration			*High Blood Pressure*	
High Cholesterol		Cataracts			*High Cholesterol*	
Thyroid Disease		Eye Surgery / LASIK			*Thyroid*	
Heart Disease		Eye Trauma			*Heart Disease*	
Stroke		Lazy Eye/Crossed Eye			*Cancer*	
Cancer		Double Vision				
Arthritis		Droopy eyelid			*Glaucoma*	
Asthma/Lung		Eye pain			*Cataracts*	
HIV/AIDS		Loss of vision			*Macular Degeneration*	
Hepatitis		Floaters / Flashes of light			*Retinal Detachment*	
Seasonal Allergies		Gritty, sandy feeling			*Crossed / Lazy Eye*	
Headaches / Migraines		Itchy / Watery / Burning eyes			*Blindness*	
If Female, currently pregnant?		Increased light sensitivity				

Hobbies: _____

Use tobacco products? ❑ YES ❑ NO Type / Amount / How Long? _____

Drink alcohol? ❑ YES ❑ NO Type / Amount / How Long? _____

Use illegal drugs? ❑ YES ❑ NO Type / Amount / How Long? _____

RETINAL EYE SCREENING PHOTOS

This is scan of your retina helps with early detection of retinal diseases such as macular degeneration, glaucoma, diabetic retinopathy, high cholesterol, high blood pressure, retinal holes and cancers. These conditions can lead to serious health problems including loss of vision and often develop without warning or symptoms. The images will allow the doctor to document, review, and compare your retina over time without dilation.

*****STRONGLY RECOMMENDED***** Most insurances cover the retinal photos with a **$35 copay**.

❑ **YES**, I want the retinal photos ❑ **NO**, I do **not** want the retinal photos

DILATED FUNDUS EXAM

This procedure enables the doctor to provide a more thorough ocular health analysis. With dilation, we get a better view inside the eye that allows us to detect early signs and changes of ocular pathologies. This is extremely essential for individuals with diabetes, hypertension, high myopes (nearsighted), and/or any history of other related diseases. The drops will enlarge the pupils and cause temporary blurred vision at near and light sensitivity for about 4-6 hours.

❑ **YES**, I want the dilated fundus exam ❑ **NO**, I do **not** want the dilated fundus exam