**Eye Care Registration and History**

**Patient Information**

Patient’s Name (Last) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M or F \_\_\_\_\_\_\_

Date of Appointment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Texting OK? Yes\_\_\_No\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Last Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Medical Information: Check the box if you have a problem with any of the following system**

Gastrointestinal Nervous System Mental

Ear/Nose/Throat Genitourinary Endocrine (Glands)

Cardiovascular Musculoskeletal Blood/Lymph

Respiratory Skin Allergic/Immunologic

Headaches Surgeries (What type and when) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you in good health? Yes No

Do you smoke? Yes No How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink? Yes No How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take Medication(s)? Yes No Names and how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Do you use other substances? Yes No

Are you allergic to any medications or other substances? Yes No

If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name/Address/Phone Number of your Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Family History. Has anyone in your family had any of the following? If yes, Please check the box.**

Diabetes Glaucoma High Blood Pressure

Macular Degeneration Retinal Detachment Cataracts

Please explain any of the boxes you have checked \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Do you have any of the following? If yes, please check the box.**

Blurred Vision Eye Surgeries Wear Glasses

Dry Eyes Eye injuries Wear Contacts

**What brings you to the office today?**

Annual Eye Exam Medical Exam

Contact Lens Exam Other (Please Explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (**Please continue on next page**🡪)

**Billing and Insurance**

Primary Health Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Plan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plan Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Employer/ School\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Name (as it appears on insurance card or ID) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Phone number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_ Zip code \_\_\_\_\_\_\_\_\_\_

Insured’s Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Protected Health Information Release**

I authorize the release of any Protected Health Information necessary to process insurance claims, or to provide treatment. I also request payment of all government and insurance benefits be payable to Dr. Desmond Parkin. I am responsible for the deductible, co-insurance and all non-covered services. I acknowledge that I have been afforded the opportunity to review the Notice of Privacy Practices and have been given a copy if requested.

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

**Authorization Related to communications between the office of Sharper Vision and the undersigned patient**

I authorize the transmission of communications using the following methods:

Note: If the method of communication may result in your Protected Health Information being shared with others, you are acknowledging that possibility. You may choose to limit how and what is communicated below:

I WILL ALLOW ONLY THE FOLLOWING INFORMATION TO BE COMMUNICATED

APPOINTMENT TIME

EYE GLASSES OR CONTACT LENSES READY TO BE PICKED UP

PAYMENT REQUIRED, INCLUDED AMOUNT AND DATE DUE

ISSUES REGARDING YOUR INSURANCE

I WILL ALLOW ANY AND ALL COMMUNICATIONS WHICH MAY INCLUDE RESULTS OF TESTS, NEED FOR STATUS OR REFERRAL TO ANOTHER PRACTITIONER AND OTHER ITEMS NOT SPECIFICALLY LISTED HERE.

BY ANY METHOD AS PROVIDED ON YOUR INTAKE FORM, OR SPECIFICALLY BY:

HOME TELEPHONE

CELLPHONE

WORK TELEPHONE

HOME ANSWERING DEVICE

WORK ANSWERING DEVICE

EMAIL

TEXT (CELLPHONE ABOVE)

**Billing and Insurance**

To Our Patients:

You are being asked to completely fill this credit card authorization form which will be scanned into and held securely in our computer system. This form will then be shredded. We will bill your insurance first. If your insurance then makes a determination of the amount of your patient responsibility (such as additional co-pay, co-insurance, **deductible**; ect.) the remaining balance owed by you will be charged to your credit card and a receipt will be mailed to you.

This in no way will compromise your ability to dispute a charge or an insurance company’s determination of payment.

Co-pays are still due at the time of the visit.

Respectfully yours,

Dr. Desmond Parkin O.D

Sharper Vision

I authorize Sharper Vision Optical (Dr. Desmond Parkin O.D) to charge outstanding balances on my account (not covered or payed for by my insurance) to the following credit or bank card.

Card: Visa\_\_\_\_\_ MasterCard\_\_\_\_\_ American Express\_\_\_\_\_ Discover\_\_\_\_\_

Card/Account number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp date:\_\_\_\_\_/\_\_\_\_\_ Billing zip code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security Code (4-didgits for Amex and 3 for others) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name as it appears on the card (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Or please check below and sign above if applicable:

\_\_\_\_\_ By my own solemn oath I do not have a credit card or bank card, I agree to pay for any outstanding balance I am responsible for according to my insurance plan/policy or if my insurance does not pay for services that I have been rendered.

\*Statements will be mailed twice. Unpaid balances after 60 days will be forwarded to a collection agency. I understand that I will be responsible for balances and collection fees and collection fees and a $25 service charge. \*