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www.parkfamilyeyecare.com

Park Family Eye Care
WELCOME TO OUR OFFICE
NEW Patient History Form

Doctors of Optometry
Bill M. Park, O.D.
Lena G. Park, O.D.
Jeffrey L. Harris, O.D.

Last Name: (please print) _____ **First Name** _____ **MI** _____
Address _____ **City** _____ **State** _____ **Zip** _____
Phone (H) _____ **(Work)** _____ **(Cell)** _____
Date of Birth _____ **SSN** _____ **Occupation** _____ **Employer** _____
Family Members: Spouse _____ **Children:** _____
Date of last eye exam: _____ **Dilated?** Y N **Whom may we thank for referring you?** _____
Preferred Language: _____ **Preferred Communication:** Email Postal Telephone
Race: American Indian/Alaskan Native Asian Black/African American Hispanic Native Hawaiian/Pacific Islander White Decline to specify
Ethnicity: Hispanic or Latino Native Hawaiian/Pacific Islander Not Hispanic or Latino Decline to specify
Text Reminder? Y N E-Mail _____ **E-Mail Reminder? Y N** _____

What is the reason for your visit today? Please mark all that apply

_____ annual exam	_____ contact lenses	_____ eye pain/discomfort	_____ interested in LASIK
_____ blur at distance	_____ computer strain	_____ flashes/spots	_____ itching
_____ blur at near	_____ double vision	_____ glaucoma	_____ lazy eye
_____ broken glasses	_____ dry eyes	_____ headache	_____ tears/discharge

Do you wear glasses? Y N Age of current pair? _____ Are you satisfied with your frames/lenses? Y N
Do you wear contact lenses? Y N Type? Hard Disposable Other Brand? _____
Do you wear sunglasses? Y N

Name of Family Doctor/Internist First name _____ Last Name _____
Phone # _____ City _____ Date of last visit _____
List any **MEDICATIONS** you currently take **Over the counter** _____
Rx - _____

Environmental Allergy _____ **Medication Allergy** _____ **Reaction to Allergy** _____
Pharmacy _____ **Street** _____ **City** _____

Height _____ **Weight** _____ **Females – Are you pregnant?** Y N

Do you have or have ever been treated for:

Allergies Y N	Depression Y N	High blood pressure Y N	STD Y N
Anxiety Y N	Diabetes Y N	HIV Y N	Stroke Y N
Arthritis/Joint Pain Y N	Headache Y N	Kidney/Urinary Y N	Stomach problems Y N
Breathing problems Y N	Hearing loss Y N	Sinus Y N	Thyroid/glands Y N
Cancer Y N	Heart Disease Y N	Skin Condition Y N	Other _____

Have you had any eye operations or injuries? Y N Type _____ Date _____

Family History - Indicate family member: Father, Mother, Siblings- ex: MGM (maternal grandmother) PGM (paternal grandmother)

Blindness _____	Diabetes _____	Lazy eyes _____
Cataracts _____	Glaucoma _____	Macular degeneration _____
Crossed eyes _____	High Blood Pressure _____	Retinal Detachment _____
Other _____		

Social History

Do you use any cigarettes/tobacco? Y N If YES, Packs per day _____ # of Years _____
Have you ever used cigarettes/tobacco? Y N If YES, How many years ago did you stop smoking? # of Years _____
Do you drink alcohol? Y N If YES, Frequency _____
Other substance(s)? Y N If YES, Frequency _____

Professional fees are due at the time of service. A \$10 billing charge will be applied without exception to any outstanding balance and will accrue monthly. **There will be a \$35 fee if a check is returned for any reason.** Patients are responsible for all costs associate with collection or legal actions. **All insurance information should be provided before service begins.**

I authorize the eye doctor to release any information including diagnosis and the records of any treatment or examination of me, or my child, during the period of eye care to third party payers. I acknowledge that I have read the **PRIVACY ACT FORM (HIPAA)**. A copy of the PRIVACY ACT FORM is available if you would like one).

This information is accurate and was given by:

PATIENT SIGNATURE _____

DATE _____

Physicians Initials _____