



David M. Sparks, O.D.

Patient Registration and Medical History Form

First Name: _____ Last Name: _____ Middle Initial: _____ Preferred Name: _____

Birth Date: _____ Social Security Number: _____ Insured's Name: _____ Sex: **M / F**

Home Address: _____ Zip: _____ City: _____ State: _____

Which phone number would you prefer we use to contact you? Home Work Cell Home Phone: _____ Work Phone: _____

Cell Phone: _____ Pager: _____ E-mail address: _____

Marital Status: Single Married Other Referred by: _____ ***We must have a copy of all insurance cards on the day of service**

Primary Medical Insurance: _____ Secondary Medical Insurance: _____

Vision Insurance: _____ Insured Social Security Number: _____

Insured's Birth Date: _____ Insured's Employer: _____

Family Doctor: _____ Family Dr. Clinic/Phone: _____

Family Members: _____ For ease of data transfer, are they patients at this office? **Y / N**

Method of Payment for Today's Services: Cash Check Visa MasterCard Discover

NOTICE OF PRIVACY PRACTICES: I/We have been offered a copy of Hillsville Family Eye Care, PLLC statement on privacy practices
AUTHORIZATION TO RELEASE INFORMATION: I/We hereby authorize Hillsville Family Eye Care, PLLC to release any medical or incidental information that may be necessary for medical benefit or in processing applications for financial benefit. This includes but is not limited to other health care providers, my insurance company, Rehabilitation Services, Social Security Administration, and Worker's Compensation.
Hillsville Family Eye Care, PLLC may file by mail, fax, or telephone data to insurance companies assisting in the payment of fees. As required, Hillsville Family Eye Care, PLLC may use personal or medical information to assist in compliance issues, medical or peer review, insurance surveys, or other ways that are deemed by Dr. Sparks necessary for my medical management or as required by contractual agreements between Hillsville Family Eye Care, PLLC and other third party companies. Hillsville Family Eye Care, PLLC is not responsible for how other companies or agencies use my personal or medical information.
CONSENT FOR TREATMENT: I/We hereby authorize Hillsville Family Eye Care, PLLC to administer diagnostic and medical procedures as may be necessary for proper health care. In accordance with the Health Insurance Portability and Accountability Act, I authorize Dr. Sparks and/or any member of his staff to coordinate my medical care with other healthcare professionals, insurance companies and/or my immediate family members (i.e. spouse, parents, children).
OFFICE POLICY ON PAYMENT: I understand that I am responsible for payment of all charges. As a courtesy, my insurance will be billed for me. It is my responsibility to pay any deductible, copay or any other balance not paid by my insurance company. I authorize insurance benefits to be paid directly to the provider.
VISION PLAN COVERAGE: I/We understand that only one vision plan may be used for exam/materials per visit-per patient and that the vision plan to be used must be chosen before the exam occurs and can not change at later date.
TELEPHONE CORRESPONDENCE: Hillsville Family Eye Care, PLLC may contact me at the phone number(s) that I have provided. Hillsville Family Eye Care, PLLC may leave a telephone message on my answering machine or with anyone else in the household for me regarding confirmation of eye examination appointments, availability of eyeglasses / contact lenses for pick-up, etc.

SIGNATURE: _____ DATE: _____

CHIEF COMPLAINT

How can we help you today? In this space please check/explain any signs and/or symptoms you are experiencing. Medical insurance will only cover if there is a medical reason for the exam/test such as loss of vision, headaches, eye pain, eye itching or burning, redness, glaucoma, cataracts, floaters, dry eyes, etc.

- Loss of vision Floaters Eye pain/soreness Glare Dry eyes
- Blurred vision Crossed eyes Watery eyes Light sensitivity Red eyes
- Double vision Flashes of light Sandy/gritty feeling Tired eyes Burning/itching

Other (explain): _____

HISTORY OF PRESENT ILLNESS

Please select any and all that apply. (You may select more than one answer per category. For example, your LEFT eye may be experiencing blurry DISTANCE vision.)

Location Which eye has the problem and where do you notice the problem?

- Right Left Both Distance Vision Near Vision Intermediate Vision Upper Lid Lower Lid Globe Brow Other _____

Quality How is it effecting you?

- Itch Burn Blur Sharp Pain Dull Plain Aching Pain Other _____

Severity How severe is the problem?

Mild Moderate Severe Other _____

Duration How long have you had the problem?

Minutes Hours Days Weeks Months Intermittent Other _____

Timing When does this occur?

Morning Mid-day Afternoon Evening All Day All Night Constant Other _____

Context What is it associated with?

During Work During Recreation Driving Reading School Near Work Other _____

Modifiers Have you attempted any previous treatment?

Rx Medication OTC Medication Cold Compress Warm Compress Glasses Contact Lenses Stop Activity Rest Other _____

Symptoms Are there associated symptoms?

Headache Redness Pain Watering Swelling Double Vision Fatigue Other: _____

Patient HISTORY

When & where was your last eye exam? _____ When & where was your last physical examination? _____

Have you ever been diagnosed with any of the following eye problems (check all that apply): If **yes**, please make note in this area. **EXAMPLE:** I had a lazy eye as a child, amblyopia.

No problems Glaucoma Cataracts Macular degeneration Ocular Surgery Amblyopia

Have you ever been diagnosed with any of the following (check all that apply):

No problems Diabetes High blood pressure Cancer

FAMILY HISTORY

Has anyone in your family been diagnosed with any of the following eye problems (check all that apply): If **yes**, please make a note of relationship to patient.

EXAMPLE: Father had cataracts.

No problems Glaucoma Cataracts Macular degeneration

Relation to patient _____

Has anyone in your family been diagnosed with any of the following (check all that apply): If **yes**, please make a note of relationship to patient.

EXAMPLE: Sister has diabetes.

No problems Diabetes High blood pressure Cancer

Relation to patient _____

SOCIAL HISTORY

Do you smoke?

Y N

If yes, what do you smoke?

Cigarettes Cigars Pipes

How much per month do you smoke? _____

Do you consume alcohol?

Y N

If yes, how much do you drink? _____

What is your occupation? _____

CURRENT VISION

Glasses: Do you currently wear glasses?

Y N if yes, please answer the questions below; if no, continue to contact lenses section:

What type of lenses are in your glasses?

Single vision Bifocal Trifocal No-line (Progressive)

Contact Lenses: Do you currently wear contact lenses?

Y N if yes, please answer the questions below; if no, continue to past ocular history section:

What type of contact lenses do you wear?

Soft Rigid

What is the manufacturer/model of your contact lenses?

What are the powers of your contact lenses (if you know)?

How old are your current contact lenses?

_____ Months / Years

How often do you replace your contact lenses?

Daily Weekly 2 weeks Monthly 3 months 6 months Annually

What solutions do you use to care for contact lenses? Renu Optifree Clear Care Boston Advance Boston Simplicity Optimum Other: _____

REVIEW OF SYSTEMS

Ocular/Eye Problems

- Inflammatory disorder Y N
Surgery Y N
Glaucoma Y N
Amblyopia (lazy eye) Y N
Cataract Y N
Retinal problems Y N
Macular degeneration Y N
Strabismus (eye turn) Y N
Patching Y N
Other _____

Constitutional Problems

- Cancer Y N
Fatigue Y N
Developmental disability Y N
Other _____

Ears, Nose, Mouth, Throat Problems

- Laryngitis Y N
Dry mouth Y N
Hearing loss Y N
Sinusitis Y N
Other _____

Neurological Problems

- Cerebral palsy Y N
Multiple sclerosis Y N
Tumor Y N
Epilepsy Y N
Other _____

Psychiatric Problems

- Depression Y N
Other _____

Cardiovascular Problems

- Vascular disease Y N
Stroke Y N
Congestive heart failure Y N
Heart disease Y N
High blood pressure Y N
Other _____

Respiratory Problems

- Emphysema Y N

- Bronchitis Y N
Smoker Y N
COPD Y N
Asthma Y N
Other _____

Gastrointestinal Problems

- Colitis Y N
Chron's disease Y N
Ulcer Y N
Other _____

Genitourinary Problems

- Prostate disease/cancer Y N
STD Y N
Kidney disease Y N
Other _____

Musculoskeletal Problems

- Ankylosis spondylitis Y N
Fibromyalgia Y N
Muscular dystrophy Y N
Osteoarthritis Y N
Other _____

Skin Problems

- Rosacea Y N
Psoriasis Y N
Eczema Y N
Other _____

Endocrine Problems

- Insulin dependent diabetes Y N
Hormonal dysfunction Y N
Thyroid dysfunction Y N
Non-insulin diabetes Y N
Other _____

Blood/Lymph Problems

- Large volume blood loss Y N
Anemia Y N
Other _____

Allergy/Immunologic Problems

- Environmental allergies Y N
Rheumatoid arthritis Y N
Drug allergies Y N
Other _____

- Lupus Y N

Do you sometimes experience dry eyes?

Y N

Are your eyes sensitive to sunlight?

Y N

Do you work at a computer ?

Y N

Problems with reflections and/or glare?

Y N

Prefer not to wear your glasses at times?

Y N

Interested in newer contact lens technology?

Y N

Want information on thinner / lighter lenses?

Y N

Please list your sporting activities / hobbies:

List any medications you are currently taking:

List any medicine ALLERGIES:

List any other ALLERGIES: