

First Name	MI	Last Name		Birthdate	
Street Address	City		State	Zip Code	Male/Female
Home Phone Number	Preferred Number To Call			Email	
Name of Emergency Contact			Relation	Phone Number	
ID #1			ID#2		
Name of Insurance			Name of Insurance		

Please indicate if you or your blood relatives have any of these conditions that may affect the eyes

Eye Problems	Self	Family	Neurologic Problems	Self	Family	Constitutional Problems	Self	Family
<input type="checkbox"/> Glaucoma			<input type="checkbox"/> Multiple Sclerosis			<input type="checkbox"/> Cancer		
<input type="checkbox"/> Retinal Detachment			<input type="checkbox"/> Myasthenia Gravis			<input type="checkbox"/> General Illness		
<input type="checkbox"/> Macular Degeneration			<input type="checkbox"/> Other			<input type="checkbox"/> Other		
<input type="checkbox"/> Other			Musculoskeletal Problems			Integument (Skin)Problems		
Endocrine Problems			<input type="checkbox"/> Arthritis			<input type="checkbox"/> Eczema		
<input type="checkbox"/> Diabetes			<input type="checkbox"/> Lupus			<input type="checkbox"/> Other		
<input type="checkbox"/> Thyroid Disease			<input type="checkbox"/> Other			Gastrointestinal Problems		
<input type="checkbox"/> Other			Respiratory Problems			<input type="checkbox"/> Chrohn's Disease		
Cardiovascular Problems			<input type="checkbox"/> Asthma			<input type="checkbox"/> Ulcers		
<input type="checkbox"/> Heart Disease			<input type="checkbox"/> Sleep Apnea			<input type="checkbox"/> Other		
<input type="checkbox"/> High Blood Pressure			<input type="checkbox"/> Other			Psychiatric Disorders		
<input type="checkbox"/> Other			Allergy/Immunology Problems			Genito-Urinary Problems		

Please list conditions not covered above affecting you (include pregnancy, nursing, prior trauma or surgeries)

Please list medications and eyedrops that you use (include over the counter medicines)

Social Information (Please mark if these apply to you) Smoke Use Alcohol Use Recreational Drugs

Height _____ **Weight** _____

Financial responsibility and assignment of insurance benefits:

I guarantee payment to Parkside Optometry of all charges for services provided to the patient. I understand that I am personally responsible for all charges not covered by insurance, and I authorize payment of medical benefits to Parkside Optometry for services rendered. If covered by Medicare or Medi-Cal. I certify that the information provided by me in applying for payment under Titles V, XVIII and/or XIX of the Social Security Act is correct.

Acknowledgment of receipt of notice of privacy practices: I have received a copy of Parkside Optometry's Notice of Privacy Practices. I am aware that the Notice may be changed at any time. I may obtain a copy of the Notice at 1880 S. Norfolk St, San Mateo, CA 94403

Signature: _____ **Date:** _____