PATIENT INFORMATION

KRISTAN SPARKS O.D.
NATHAN KOHLER O.D.

Date: _____

Patient Legal Name: _____
GIVE PATIENTS NAME AS IT APPEARS ON INSURANCE CARD- ALL RECORDS WILL APPEAR UNDER THAT NAME ONLY

Sex: Male Female **Marital Status:** Single Married Divorced Widowed

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Billing address (if different than above): _____

Phone: **Cell** _____ **Home** _____ **Work** _____

Preferred Method of Contact: Cell Home Work

Patient's Data: **If Married:**

Patient's Date of Birth: _____ **Spouse Name:** _____

Patient's SS#: _____ **Spouse Date of Birth:** _____

Patient's Employer: _____ **Spouse SS#:** _____

Occupation: _____ **Spouse Employer:** _____

If minor, name of Parents: _____

Name of Person Responsible for this account if other than patient _____

Payment Information:

_____ Private Pay
_____ Vision Insurance
_____ Medical Insurance
Primary: _____
Member's Name: _____
Member's Unique I.D.: _____
Group Number: _____

Reason for Today's Exam _____

Date of Last Vision Exam _____ **Dr.:** _____

Date of Last Medical Exam _____ **Dr.:** _____

Please list any medications you are currently taking and for which condition:

_____

_____

(Please turn over to finish)

Do you or anyone in your immediate family (Parents, grandparents, siblings, children) have any of the following:
(Please circle and **INCLUDE** whom has/had the condition.)

Autism	High Blood Pressure	Blindness	Macular Degeneration
Cancer	Stroke	Cataracts	Turned out "Lazy" eye
Diabetes	Glaucoma	Keratoconus	Vision related learning Disability
Heart Condition	Thyroid Condition		

Do any of the following conditions apply to you?

ADD/ADHD	Cornea Transplant	Head Injury	Sinus Trouble
Anxiety	Drug allergies	Seasonal Allergies	
Asthma	Frequent Headaches	Pregnancy	

Have you ever had any of the following conditions involving eyes?
(Please circle all that apply)

Double Vision	Eyes itch/burn/water	Light Sensitivity	Severe pain/eyestrain
Eye infections/Disease	Flashes of light	Poor Distance vision	Temporary vision loss
Eye Injury	Floaters in Vision	Poor Near vision	Vision Therapy

What hobbies or sports do you enjoy? _____

Do you work at a computer? NO YES Hours per day (average) _____

Do you currently wear glasses? NO YES Reading/Distance/Sunglasses/Computer/ Progressive
(Please circle all that apply)

Do you currently wear contacts? NO YES Soft/Disposable/ Hard/ Non Disposable
(Please Circle)

☐ I authorize the release of my medical and/or other information pertaining to my (or minor child's) care by Dr. Kristan Sparks or Dr. Nathan Kohler.

We are in compliance with Protected Health information, if you would like to see the disclosure form, please request a copy. Please sign your acknowledgements of this form.

_____
Printed Name Relationship

_____
Signature Date

YEARLY UPDATE

Initial/Date_____
Initial/Date_____
Initial/Date_____
Initial/Date_____
Initial/Date_____

Please check the reason you chose us for your vision care

Previous Patient: _____	Mailer: _____	School Referral: _____
Physician Referral: _____	QuestDex: _____	Newspaper: _____
Family Referral: _____	Yellow Book: _____	Other: _____