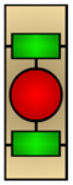

# MISSION OPTICAL

18646 DIXIE HWY HOMEWOOD, IL. 60430 (708)647-6635

## NEW PATIENT INFORMATION

### PART – A (ADULT) DATE:

NAME:_____M__F__BIRTHDATE____/____/_____

ADDRESS_____CITY_____

STATE_____ ZIP CODE_____ PHONE HOME (___) _____

EMERGENCY PHONE (___) _____ PHONE CELL (___) _____

SOCIAL SECURITY #_____-____-_____ EMAIL_____

SPOUSE NAME_____ DOB____/____/_____ SOC.SEC. #_____-____-_____

### PART – B (CHILD) DATE:

CHILD'S NAME_____M__F__BIRTHDATE____/____/_____

CHILD LIVES WITH: (PLEASE CIRCLE) BOTH PARENTS MOTHER FATHER

FATHER'S FULL NAME_____ PHONE HOME (___) _____

PHONE WORK (___) _____ PHONE CELL (___) _____

HOME ADDRESS_____CITY_____STATE____ZIP_____

BIRTHDATE____/____/_____ SOC.SEC.#____-____-_____

MOTHER'S FULL NAME_____ PHONE HOME (___) _____

PHONE WORK (___) _____ PHONE CELL (___) _____

HOME ADDRESS_____CITY_____STATE____ZIP_____

BIRTHDATE____/____/_____ SOC.SEC.#____-____-_____

### PATIENT AUTHORIZATION

I authorize the release of any medical information necessary to process this claim and request payment of medical benefits to : **MISSION OPTICAL**

I hereby authorize my insurance benefits to be paid to **MISSION OPTICAL** realizing I am responsible to pay non-covered services

SIGNATURE_____

SIGNATURE_____

# Mission Optical

18646 Dixie Hwy Homewood, IL. 60430 (708)647-6635

## MEDICAL INFORMATION

Name_____ Date_____

### Medical History

*Cardiac*
-High Blood Pressure
-Irregular Heart Rhythms
-Other:
_____

*Respiratory*
-Asthma/COPD
-Use of Oxygen
-Other:
_____

*Endocrine*
-Diabetes
-Thyroid
-Other:
_____

*Rheumatologic*
-Arthritis
-Poly or Fibromyalgia
-Other:
_____

*Ear/Nose/Throat*
-Sinus Problems
-Dizziness
-Other:
_____

*Gastrointestinal*
-Ulcers/Reflux
-Colitis
-Other:
_____

*General*
-Depression
-Environmental Allergies
-Other:
_____

*Neurological*
-Prior Stroke
-MS
-Other:
_____

*Hematologic*
-Anemic
-Bleeding Problems
-Other:
_____

### Family History

-Any Significant family history of unusual medical or eye problems?

_____
_____
_____

-Any significant general or eye surgeries?

_____
_____
_____

### Eye History

-Cataracts
-Glaucoma
-Macular Degeneration
-Lazy Eye (Amblyopia)
-Eye Trauma
-Other:

### Social History

-Occupation_____
-Tobacco Use:
NO YES
-Alcohol Use:
NO YES
-Hobbies with visual issues:

### Allergies

_____
_____
_____
_____

### Medications

_____
_____
_____
_____
_____

MISSION OPTICAL
18646 DIXIE HWY HOMEWOOD, IL. 60430 (708)647-6635

## HEALTH PRIVACY POLICY REVIEW

NAME_____ DOB_____

**Notification of Patient Privacy Protection:**
**The HIPPA Act**

These enclosed pages describe how patient medical information may be used and who can have access to this information. We will be happy to answer any question you may have. Mission Optical's notice of privacy practices are available for viewing upon request.

I have reviewed and understand the **Mission Optical** notice of privacy practices:

_____ ____/____/_____
Signed Patient or Patient's Representative Date

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I prefer to receive my medical information by one or all of the checked methods:

- ☐ In Person Only
- ☐ By Home Phone
  - ☐ I prefer leaving my medical information/results on a message
- ☐ By Cell Phone
  - ☐ I prefer leaving my medical information/results on a message

_____ ____/____/_____
Signed Patient or Patient's Representative Date

---

I authorize the following person(s) to receive medical information on my behalf

Name_____ Relation_____

Name_____ Relation_____

Name_____ Relation_____

I hereby declare the above listed person(s) to be eligible to receive medical information on my behalf.

_____ ____/____/_____
Signed Patient or Patient's Representative Date

**Your Preferred Pharmacy:**

Pharmacy Name: _____

Address: _____

City: _____

**Your Primary Doctor:**

Doctor's Name: _____

Address: _____

City: _____

**Your Email: _____**