PARKHURST • NUVISION

ADVANCED VISION CORRECTION

NUVISION CONSULTATION INFORMATION

DATE: _____/_____/_____

PLEASE PRINT

Dr. Mr. Mrs. Ms. _____ Nickname _____ ☐ Male ☐ Female

Address: _____ City/State: _____ Zip: _____

Cell Ph: _____ Wk Ph: _____ Email: _____

Age:_____ DOB.:_____/_____/_____ SS#:_____-_____-_____

Primary Occupation: _____ Favorite Hobbies: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other: _____

Optometrist Name: _____ Approx. Date of Last Visit: _____

Do you wear: ☐ Contacts ☐ Glasses ☐ Both ☐ Neither

Ocular History		
Keratoconus	Y	N
Corneal Injury or Surgery	Y	N
Corneal Dystrophy	Y	N
Herpes Eye Disease	Y	N
Dry Eyes	Y	N
Glaucoma	Y	N

List Other: _____

Medical History		
Diabetes or endocrine disorder	Y	N
Autoimmune/Collagen Vascular Dis.	Y	N
Pregnant or nursing	Y	N
Keloid	Y	N
On Amiodarone, Accutane, or Immitrex	Y	N

Drug Allergies: _____

List Current Meds: _____

Where did you hear about us? ☐ Online ☐ Vision Insurance ☐ Advertisement

☐ Doctor: _____ Friend/Relative: _____ ☐ Other: _____

Do you have health insurance? Yes No Please List _____

Do you have vision insurance? Yes No Please List _____

I hereby authorize Dr. Gregory Parkhurst & Associates to provide a diagnosis & ophthalmic treatment to me or my child. I further authorize the release of Protected Health Information to additional physicians or optometrists in order to facilitate continuity of care. I have read & understand the above information & am signing this form voluntarily.

_____ _____

Signature Date

Internal Office Use Only: Demos and Scanning verified by: