Doctors Park Eye Clinic & Optical
STUCKEY * MOSELEY * WATKINS
9600 Baptist Health Dr. Suite 230
Little Rock, AR 72205 501.227.6797

PLEASE COMPLETE ALL INFORMATION REQUESTED BELOW

Today's Date:_____
Patient Name: _____ **DOB:** _____
Address:_____ **City:** _____ **State:** _____ **Zip:** _____
SS#:_____
Home phone: _____ **Cell phone:** _____ **Email:** _____
Employer: _____ **Work phone:** _____
Age:____ **Sex:**____ **Marital Status:** ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated
Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino **Language:** _____ **Race:** _____
Smoking Status: Current Smoker Current/Some day Smoker Former Smoker Never Smoker
Family/PCP Doctor: _____ **Address:** _____ **Phone:** _____
Referred By: _____ **Address:** _____ **Phone:** _____
Has your doctor forwarded information to us? _____ Have you seen Dr. Moseley/Stuckey/Watkins as a patient in this office before today? _____Reason for your visit _____
Emergency contact person _____ Phone _____
Alternate Emergency contact (not living with you) _____ Phone _____
Drug Allergies _____

PRIMARY INSURANCE

Medicare # _____
Insurance Co. Name _____
Group # _____
ID # _____
Name/Policy Holder _____
DOB _____ SS# _____
Relationship to insured:_____

SECONDARY INSURANCE

Medicare/Medipak # _____
Insurance Co. Name _____
Group # _____
ID# _____
Name/Policy Holder _____
DOB _____ SS# _____
Relationship to insured:_____

COMPLETE THIS SECTION ONLY IF PATIENT IS A MINOR

Parent/Legal Guardian _____
Address _____
#1 Phone _____ SS# _____
Employer _____
Address _____ Phone _____

Parent/Legal Guardian _____
Address _____
#1 Phone _____ SS# _____
Employer _____
Address _____ Phone _____

****Is this visit work related? *YES/NO*** ***If YES, PLEASE provide worker's comp information below:***
Employer Name & Address: _____
Employer Phone # & Contact Person: _____

- **ACKNOWLEDGEMENT OF ADVANCE NOTICE (Medicare Patients ONLY):** I hereby acknowledge the notice of Advance Notice of refractive state, posted in the office of Doctors Park Eye Clinic, PLLC and understand that I am responsible for the $25.00 refraction fee at time of service, which is *NOT* covered by Medicare. _____**Patient/Guardian Initials**
- **ASSIGNMENT OF BENEFITS STATEMENT:** *I/We understand that **ALL** Co-pays are due at time of service and if any services or charges are **not** covered by my insurance carrier or my eligibility cannot be verified, **I am responsible for all charges incurred.*** _____ **Patient/Guardian Initials**
- **ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES:** I hereby acknowledge the Notice of Privacy Practices displayed in the office of Doctors Park Eye Clinic, PLLC. _____**Patient/Guardian Initials**
- **ACKNOWLEDGEMENT OF DUTY TO WARN:** I hereby acknowledge the Duty to Warn notice posted in the office of Doctors Park Eye Clinic, PLLC and understand the contents of said notice. _____**Patient/Guardian Intials**

PHONE NUMBER TO CALL WITH ANY APPOINTMENTS, REPORTS &/OR LAB RESULTS: _____

- ☐ You have my permission to leave a message at the above number
- ☐ You have my permission to discuss my medical health care with _____ *if more than one list on back
- ☐ DO NOT discuss my medical care with anyone but me

Please provide your pharmacy name and address for us to call in your prescriptions:

PRIMARY PHARMACY: _____ **PHONE #:** _____ **CITY/STREET:** _____

Signature of Patient/Parent/ Guardian/ Insured Printed Name Date

_____ _____ _____

Doctors Park Eye Clinic

John E Stuckey, OD. ~ Thomas H Moseley, MD ~ John G Watkins, MD
9600 Baptist Health Dr, Suite 230 ~ Little Rock, AR 72205

Name _____ Date _____

Family Physician _____ Referring Physician _____

Eye Physician _____ Last eye exam date _____

Eye History: Please indicate if you have or have had any of the following: □ Glaucoma □ Cataract □ Strabismus (lazy eye) □ Retina problems □ Macular degeneration □ Injuries □ Wear glasses □ Wear contacts

Other EYE problems and surgeries? _____

Review of Systems (Eye) □ Decreased vision □ Tearing □ Redness □ Discharge □ Pain □ Itching □ Burning □ Foreign body sensation □ other _____

Review of Systems (circle yes or no and if yes please explain)

Yes No Unexplained weight loss, fatigue? _____

Yes No High blood pressure, heart problems? _____

Yes No Breathing problems, cough, asthma? _____

Yes No Stomach, digestion problems? _____

Yes No Kidney, urinary problems? _____

Yes No Muscle, joint problems? _____

Yes No Skin problems, rash? _____

Yes No Headaches, seizures, nerve problems? _____

Yes No Diabetes, thyroid, hormone problems? _____

Yes No Anemia, bruising, blood problems? _____

Yes No Ear, nose, throat, sinus problems? _____

Yes No Allergies, autoimmune problems? _____

Yes No Depression, personality, psychiatric problems? _____

Height _____ Weight _____

Surgeries _____

Other medical problems _____

Conditions that run in your family (medical or eye): □ glaucoma □ lazy eye □ macular degeneration □ cataracts □ diabetes □ retina problems □ other (specify) _____

Drug allergies _____

Did you or do you: □ drink alcoholic beverages and/or □ smoke and if so, how much? _____

What is your current occupation? _____

Updated: _____

Implemented: 2/1/2012

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CURRENT MEDICATIONS LIST

Include prescription medications, over-the-counter, herbals, vitamins, minerals, dietary nutritional supplements. ***BRING COMPLETED FORM TO YOUR APPOINTMENT.***

Last Name First Name MI Date of Birth Account #

Date	Medication	Dosage	Frequency	Route of administration (oral, injection, cream, eyedrops)	Updated by: (employee MUST initial)
					○ No change
					○ No change
					○ No change
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Welcome to Doctors Park Eye Clinic Patient Portal

Patient name:

E-mail Address:

In accordance with the Affordable Care Act (ACA) of March 2010, Doctors Park Eye Clinic is offering our patients access to the Doctors Park Eye Clinic Patient Portal. Now our patients can electronically view and communicate with us the following over a secure web portal:

- Appointments
- Medical History (including disease history for you and your family, your medications, drug allergies and social status)
- Messages (such as for patient education **THIS WILL NOT BE USED FOR MEDICAL QUESTIONS**)
- Notifications to Doctors Park Eye Clinic (such as address and phone number changes)

HOW IT WORKS:

Step One: Provide our staff with your e-mail address during the patient check-in process.

Step Two: Once you have completed your visit, you will receive an invitation to the Patient Portal via the e-mail address you provided in step one.

Step Three: Simply follow the easy registration instructions contained on the Patient Portal to register. You'll be asked to answer some security questions and provide us with your own, secure password to use the portal.

That's it! You're now ready to use the portal to access your patient information, check appointments and make changes to things such as your address, phone numbers, medications and medical history.

Disclaimer:

- The Patient Portal is **NOT** meant to be used in any manner in the case of an emergency. If you should experience an emergency, you should immediately seek appropriate emergency care by calling 911 or going to the nearest urgent care center.

- Doctors Park Eye Clinic takes no responsibility for and disclaims any and all liability arising from any inaccuracies or defects in the information, software, communication lines, internet or your internet service provider, computer hardware or software or any other service device that you use to access the Patient Portal. Additionally, you are responsible for printing copies of your information if you would like to have the information available in the event that the Portal is unavailable.