

Holland Eye Clinic

Today's Date _____

Nickname _____

Patient Full Name _____ DOB _____ Social Sec # _____ Male / Female

Address _____ City/State _____ Zip _____

Home Phone _____ Cell Phone _____ Marital Status: Married / Single / Divorced / Widowed

Email Address _____

You may contact me via (check all that apply) [] Phone [] Text [] Email **WE WILL NOT SEND ADVERTISEMENTS OR SHARE YOUR INFO**

Employer/School _____ Occupation/Grade _____ City/State _____

Race: American Indian / Alaskan / Native Hawaiian / Pacific Islander / White / Asian / African American / Other

Ethnicity: Hispanic/Latino Yes/No

Currently Pregnant or Nursing? Yes/No

Primary Care Physician _____ City/State _____

Last Eye Doctor _____ City/State _____ Date of exam _____

Person Responsible for Account or Insurance Beneficiary (if minor, parent info)

Name _____ DOB _____ Relationship to patient _____

Address _____ Phone _____

Financial Waiver

I understand that if I do not have insurance, my deductible has not been met, my insurance company does not pay in full, or my insurance denies payment, I will be liable for all charges incurred. I also understand that any services found not payable by insurance will be due at the time of service.

Refraction Charge

During your exam you may receive a refraction, a test done to determine a prescription for new glasses. Some health insurance companies such as Medicare or medical only eye exam policies do not pay for the refraction. If this is the case, this amount will be due in addition to the price of your exam and collected along with any applicable co-pays at the time of check out. If you do not wish to receive refraction please notify the assisting technician.

Contact lens Exam

There is also an additional charge for the contact lens examination. Most insurance companies do not cover contact lens related visits, so I understand these charges may be my responsibility.

I authorize payment of medical benefits, if allowed by my insurance, to Drs. Holland for professional services rendered. I also authorize the release of any medical information necessary to process this claim.

Signature _____ Date _____

Do you wear glasses? **Yes / No** How often? Always / Sometimes / Work / Reading / Driving How old are your glasses? _____

Do you wear contacts? **Yes / No** Type/Brand _____ Replacement Schedule Daily / 2week / Monthly

Have you ever had eye injuries? Which eye/what happened _____

Have you ever had eye surgery? Which eye/Why _____

Are You currently using any eye drops? Name/Reason for use _____

Visual Symptoms: With Glasses / Without glasses: Please mark Right, Left, or Both

[] Blurred Vision Near	R L B	[] Dry Eyes	R L B	[] Headaches	R L B
[] Blurred Vision Distance	R L B	[] Red Eyes	R L B	[] Migraines	R L B
[] Double Vision	R L B	[] Watery Eyes	R L B	[] Loss of Vision	R L B
[] Eye Strain	R L B	[] Wandering Eyes	R L B	[] Crossed Eyes	R L B
[] Eye Infection	R L B	[] Mucus Discharge	R L B	[] Light Sensitivity	R L B
[] Eye Pain/Soreness	R L B	[] Floaters/Spots	R L B	[] Sandy/Gritty Feeling	R L B
[] Tired Eyes	R L B	[] See Flashes	R L B	[] Poor Color Vision	R L B
[] Burning Eyes	R L B	[] See Halos	R L B	[] Droopy Lid	R L B
[] Itching Eyes	R L B	[] Poor Night Vision	R L B	[] Cloudy Vision	R L B

Personal Medical History: Please check all that apply, if none apply check NONE

Cardiovascular: <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other <input type="checkbox"/> None	Endocrine: <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other <input type="checkbox"/> None	Respiratory: <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other <input type="checkbox"/> None
Constitutional: <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other <input type="checkbox"/> None	Ocular: <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Cataracts <input type="checkbox"/> Detached Retina <input type="checkbox"/> Other <input type="checkbox"/> None	Psychiatric: <input type="checkbox"/> ADHD <input type="checkbox"/> Depression/Anxiety <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other <input type="checkbox"/> None
Neurological: <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other <input type="checkbox"/> None	Musculoskeletal: <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other <input type="checkbox"/> None	Immunologic: <input type="checkbox"/> AIDS/HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other <input type="checkbox"/> None
Hematological: <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other <input type="checkbox"/> None	Gastrointestinal: <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other <input type="checkbox"/> None	Ear/Nose/Throat <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other <input type="checkbox"/> None
Dermatologic: <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other <input type="checkbox"/> None	Miscellaneous health problems:	Alcohol Use: Y N Amount: _____ Tobacco Use: Y N Amount: _____

Medication Allergies: _____

Environmental Allergies _____

FAMILY HISTORY: Has anyone in your family (Grandparents, Parents, Siblings, Aunts, Uncles, Children, living or deceased) been diagnosed with:

DISEASE/CONDITION	WHO	DISEASE/CONDITION	WHO
Retinal Detachment:	Yes/No _____	Blindness	Yes/No _____
High Blood Pressure	Yes/No _____	Cataracts	Yes/No _____
Diabetes	Yes/No _____	Glaucoma	Yes/No _____
Cancer	Yes/No _____	Crossed Eyes	Yes/No _____
Heart Disease	Yes/No _____	Macular Degeneration	Yes/No _____
Thyroid Disease	Yes/No _____	Lupus	Yes/No _____

MEDICATIONS: Please list all medications/and or drugs that you are taking, including herbal. Please include dosage and what the medication is treating:

1. _____	7. _____
2. _____	8. _____
3. _____	9. _____
4. _____	10. _____
5. _____	11. _____
6. _____	12. _____