Holland Eye Clinic

Today's Date_____

Patient Full Name_____ **DOB**_____ **Please call me**_____ **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 WIL 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 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: __Hypertension __Stroke __Heart Disease __Vascular Disease __Other __None	Endocrine: __Non-Insulin Dependent Diabetes __Insulin Dependent Diabetes __Thyroid Disease __Hormonal Dysfunction __Other __None	Respiratory: __Asthma __Bronchitis __Emphysema __COPD __Other __None
Constitutional: __Cancer __Trauma/Large Volume Blood Loss __Developmental Disability __Other __None	Ocular: __Glaucoma __Macular Degeneration __Cataracts __Detached Retina __Other __None	Psychiatric: __ADHD __Depression/Anxiety __Schizophrenia __Other __None
Neurological: __Multiple Sclerosis __Epilepsy __Cerebral Palsy __Tumor __Other __None	Musculoskeletal: __Osteoarthritis __Fibromyalgia __Muscular Dystrophy __Ankylosing Spondylitis __Other __None	Immunologic: __AIDS/HIV __Rheumatoid Arthritis __Lupus __Neurofibromatosis __Other __None
Hematological: __Anemia __Leukemia __Other __None	Gastrointestinal: __Crohn's __Colitis __Other __None	Ear/Nose/Throat __Hearing Loss __Upper Respiratory Infection __Other __None
Dermatologic: __Eczema __Rosacea __Psoriasis __Other __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._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____