HOLE Family Eye Care

WELCOME TO OUR OFFICE

Today's Date: _____

Patient Demographics

First Name: _____ MI: _____

Last Name: _____

Birthdate: _____ Age: _____

Ethnicity: Caucasian Hispanic Asian African American

American Indian Alaskan Native Decline to Specify

PO Box: _____

Street: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____

Home Phone: _____

Email Address: _____

Ok to Contact via email/text for confirmation? Y N

Occupation: _____

Employer: _____

Spouse or Parent's Name: _____

Spouse or Parent's Phone: _____

Parent's Birthdate (If this is a child's visit): _____

What is the main purpose of this visit?

_____

_____

Any problems with current contact lenses or glasses?

_____

_____

Please tell us who we can thank for referring you to us!

_____

If not referred please tell us how you found our office?

- ❑ Another Physician
- ❑ Insurance List
- ❑ Saw sign/Building
- ❑ Newspaper, Radio, TV
- ❑ Web Page: Which website? _____
- ❑ Other: _____

Insurance/Payment Information

We ONLY submit to Blue Cross Blue Shield Medical, Allegiance, Medicare, and Medicaid

For all other insurances it will be the patient's responsibility to submit for your reimbursement. Hole Family Eye Care will provide you with the proper invoices to do this.

PLEASE BE ADVISED If you are using insurance coverage for today's visit, this is a contract between you and your insurance company, not Hole Family Eye Care. Benefits quoted to the patient are based off knowledge given to us from your insurance company and therefore are not a guarantee of payment.

PLEASE PRESENT YOUR INSURANCE CARD TO THE FRONT DESK ALONG WITH THIS COMPLETED FORM

We accept payments in the form of cash/check, credit card, care credit, financial/payment plans when worked out with our office.

Payment is due at the time of service. Any unpaid accounts are subject to collections if left unpaid.

Lifestyle Questions

Check box if your answer is yes.

- ❑ Work at a computer?
- ❑ Think you might benefit from thinner, lighter lenses?
- ❑ Spend time outdoors? How many hrs/week _____
- ❑ Have prescription sun wear?
- ❑ Have family members in need of eyecare?
- ❑ Play sports? If so what _____
- ❑ Fish/hunt/shoot? (Please circle which apply)
- ❑ Are you planning on purchasing new glasses today?

Records Release

All the information entered on this form is confidential and protected under HIPAA

Many of our patients allow family members such as Spouse, Parents, or Significant Others to request information. Under requirements of HIPAA, we are not allowed to give any information without your consent. To have any information released to your family member's you must sign this form.

Patients Signature _____

I authorize Hole Family Eye Care to release my information to the following individuals.

Name _____

Relationship _____

Name _____

Relationship _____

Please complete the other side ⟶

Patient Medical History

Please list all current medications Rx & Over the Counter (Name of the medication including eye drops, vitamins, and birth control) _____

_____

_____

Allergies to Medications? Yes No

Please list: _____

_____

Patient Height: _____ft. _____in. Patient Weight: _____lbs.

If Diabetic list Blood Sugar: _____

Name of Family Physician: _____

Date of Last Physical Check-up: _____

Do you use cigarettes, chew tobacco, alcohol, or recreational drugs? (Please circle all that apply)

Are you pregnant or nursing? Yes No

Have you had any recent surgeries? _____

_____

Please check the following if you have been diagnosed with any of the following health problems:

- ☐ Allergic/Immunologic (Allergy, Rheumatoid Arthritis, Lupus)
- ☐ Eyes (Glaucoma, Cataracts, Macular Degeneration, Surgery, retinal problems)
- ☐ Musculoskeletal (MD., Osteoarthritis, Fibromyalgia)
- ☐ Cardiovascular (HTN, Heart Disease, Stroke)
- ☐ Gastrointestinal (Crones, Colitis, Ulcer)
- ☐ Neurological (MS, Epilepsy, Alzheimer's, Parkinson's)
- ☐ Constitutional (Weight Loss, Fever, Fatigue)
- ☐ Genitourinary (STD)
- ☐ Psychiatric (Depression, Schizophrenia, ADHD, Anxiety, Bipolar, Dementia)
- ☐ Ear, Nose, Throat
- ☐ Hematologic/ Lymphatic/ Oncologic (Anemia, Leukemia, Cancers)
- ☐ Endocrine (Diabetes, Thyroid, Hormone dysfunction)
- ☐ Respiratory (Asthma, Emphysema, Bronchitis)
- ☐ Integumentary (Eczema, Rosacea, Psoriasis, Rash)

Are you currently being treated for any of the above?

_____

_____

Patient Eye History

Date of last exam: _____

By whom: _____

Have you ever experienced, been diagnosed, or treated for any of the following: (Please circle all that apply)

Blurry Vision	Burning	Cataracts
Infections	Flashes of light	Glaucoma
Headaches	Eye Injury	AMD
Itchiness	Tearing	Lazy Eye
Dryness	Light sensitive	Iritis/Uveitis
Grittiness	Double Vision	Floaters/Spots
Retinal Detachment		Trouble seeing at night
Corneal Abrasions		Cross eye/Eye Turn

Have you ever tried contact lenses? Yes No

Do you currently wear contact lenses? Yes No

Patient Eye History

Check the following that apply to your family history:

Relationship:

- ☐ Hypertension _____
- ☐ Heart Disease _____
- ☐ Diabetes _____
- ☐ Cancer _____
- ☐ Blindness _____
- ☐ Macular Degeneration _____
- ☐ Glaucoma _____
- ☐ Cataracts _____
- ☐ Retinal Problems/Surgeries _____
- ☐ Lazy Eye _____
- ☐ Corneal Problems _____

I affirm that all the information is correct to the best of my knowledge. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits to the undersigned physicians or supplier for services provided.

Signature: _____ Date: _____