Welcome To Our Office

First Name _____ MI _____ Last Name _____ Preferred Name _____

Street Address _____ City _____ State _____ Zip _____

Social Security Number _____ Date of Birth _____ Cell Phone - Include Area Code _____ Work or Home Phone _____

Email Address _____ Spouse or Parent(s) Name _____ Person Responsible for Account _____

Emergency Contact _____ Emergency Phone _____ ○ Male ○ Female

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company _____

☐M ☐F _____ _____ _____

Insured's First Name MI Insured's Last Name

Insured's Social Security Number _____ Group Number _____ Insured's Date of Birth _____

Patient Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status ☐ Single ☐ Married ☐ Other

☐ Full Time Student ☐ Part Time Student ☐ Employed

Responsibility Statement

Your insurance is a method for you to receive reimbursement for fees you have paid Von Holten Eyecare for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them not with our office. It is your responsibility to pay in advance for the deductible, coinsurance or any other balances not paid for by your insurance. We will assist you in receiving reimbursement as much as possible but you are responsible in advance for your bill.

Financial Responsibility

By signing this statement you agree to be financially responsible for all charges.

Authorization to Release Medical Information

I authorize Von Holten Eyecare to release/request medical information on by behalf to/from any entity to assist in my medical care per my request. This assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered to be as valid as the original.

Private Health Information

My signature below acknowledges that I was provided the opportunity to receive/review a copy of Von Holten Eyecare's Privacy Policy Notice.

Patient Signature _____ **Date**_____

Review Of Systems: Please select all that apply

CONSTITUTION
- ○ Developmental Disabilities
- ○ Cancer
- ○ Fatigue Syndrome
- ○ Other

RESPIRATORY
- ○ Cigarette Smoker
- ○ Bronchitis
- ○ Emphysema
- ○ Chronic Obstruction
- ○ Sleep Apnea
- ○ Other

INTEGUMENTARY
- ○ Eczema
- ○ Rosacea
- ○ Psoriasis
- ○ Herpes Simplex (cold sores)
- ○ Herpes Zoster (shingles)
- ○ Other

ENT
- ○ Hearing Loss
- ○ Sinusitis
- ○ Dry Mouth
- ○ Laryngitis
- ○ Other

GASTROINTESTINAL
- ○ Crohn's
- ○ Colitis
- ○ Ulcer
- ○ Acid Reflux
- ○ Celiac Disease
- ○ Other

ENDOCRINE
- ○ Type 2 Diabetes Mellitus
- ○ Type 1 Diabetes Mellitus
- ○ Thyroid Dysfunction
- ○ Other

NEUROLOGICAL
- ○ Multiple Sclerosis
- ○ Epilepsy
- ○ Cerebral Palsy
- ○ Tumor
- ○ Stroke/CVA
- ○ Migraine
- ○ Other

GENITOURINARY
- ○ Kidney Disease
- ○ Prostate Disease/Cancer
- ○ STD- herpetic/Chlamydia
- ○ Benign Prostate Hypertrophy
- ○ Pregnant
- ○ Nursing
- ○ Herpes
- ○ Chlamydia
- ○ Other

HEMOTOLOGIC/LYMPHATIC
- ○ Anemia
- ○ Large-volume blood loss
- ○ Ulcer
- ○ Hypercholesterolemia
- ○ Other

PSYCHIATRIC
- ○ Depression
- ○ Attention Deficit
- ○ Anxiety Disorder
- ○ Bipolar Disorder
- ○ Other

ALLERGIC/IMMUNE
- ○ Drug Allergies
- ○ Environmental Allergies
- ○ Rheumatoid Arthritis
- ○ Lupus
- ○ Sjogren's Syndrome
- ○ Other

MUSCULOSKELETAL
- ○ Arthritis
- ○ Osteoarthritis
- ○ Fibromyalgia
- ○ Muscular Dystrophy
- ○ Ankylosing Spondylitis
- ○ Osteoporosis
- ○ Gout
- ○ Other

CARDIOVASCULAR
- ○ Hypertension (high blood pressure)
- ○ Stroke/CVA
- ○ Heart Disease
- ○ Vascular Disease
- ○ CHF (congestive heart failure)
- ○ Other

Medications

Medication Name	Dose	Frequency

Medication Allergies		Environmental Allergies

Past Ocular History: Please select all that apply

○ Age Related Macular Degeneration	○ Inflammatory Disorder	○ Keratoconus
○ Retinal Degeneration	○ Glaucoma Suspect	○ Glaucoma
○ Retinal Detachment	○ Amblyopia	○ Nystagmus
○ Retinal Hole	○ Surgery	○ Patching
○ Dry Eye	○ Injury	○ None
○ Cataracts	○ Other	

Family History: Circle all that apply

Diabetes Mellitus Type 1:	Mother	Father	Brother	Sister	Son	Daughter
Diabetes Mellitus Type 2:	Mother	Father	Brother	Sister	Son	Daughter
Diabetes Mellitus in first degree:	Mother	Father	Brother	Sister	Son	Daughter
Cancer:	Mother	Father	Brother	Sister	Son	Daughter
Hypertension:	Mother	Father	Brother	Sister	Son	Daughter
Hyperthyroidism:	Mother	Father	Brother	Sister	Son	Daughter
Hypothyroidism:	Mother	Father	Brother	Sister	Son	Daughter
Cataract:	Mother	Father	Brother	Sister	Son	Daughter
Degenerative Disorder of Macula:	Mother	Father	Brother	Sister	Son	Daughter
Glaucoma:	Mother	Father	Brother	Sister	Son	Daughter

Social History

Drinking? Yes No
Amount and Frequency:_____

Smoking? Yes No Amount:_____ Type: Cigarettes Cigars Pipe Smokeless Other

Current Every Day Smoker	Current Some Day Smoker	Former Smoker
Heavy Tobacco Smoker	Light Tobacco Smoker	Never Smoker

Do we have your approval to contact you when your glasses or contact lenses arrive and appointment reminders?

	Yes	No
Phone	☐	☐
Text message	☐	☐
Email	☐	☐

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