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 _____

☐ Male ☐ Female ☐ Other _____ Email Address _____ Spouse or Parent(s) Name

Emergency Contact _____ Emergency Phone _____ Person Responsible for Account _____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company _____

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	□	□

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Von Holten Eyecare make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Von Holten Eyecare's Notice of Privacy Practice and agree to continue my care with Von Holten Eyecare under said terms.
- ☐ I was given to opportunity to read Von Holten Eyecare's Notice of Privacy Practices and declined but wish to continue my care with Von Holten Eyecare under the terms of Von Holten Eyecare's privacy policies.
- ☐ I have read or had explained to me Von Holten Eyecare's Notice of Privacy Practice and do not wish to continue my care with Von Holten Eyecare under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

  _____
  _____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____
Patient Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____
Representative Relationship to Patient

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Von Holten Eyecare to release my records and any information requested to the following individuals.

1. **_____ Relation to Patient:_____**
2. **_____ Relation to Patient:_____**
3. **_____ Relation to Patient:_____**
4. **_____ Relation to Patient:_____**

Authorization Regarding Messages
(please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments
____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information
____ I authorize you to leave a message with anyone who answers the phone
____ Messages may only be left with _____

_____ _____
Patient Name (PLEASE PRINT) Date

_____
Patient Signature