WELCOME TO OUR OFFICE

Today's Date:____________________________________

Patient Demographics

Last Name: _________________________ Age:_________

First Name: _____________________ MI: _____________

Birthdate: _____________ SSN: _____________________

Ethnicity: Caucasian Hispanic Asian African American

PO Box:____

Street: ____

City: ________________ State:_______ Zip: _________

Preffered Phone:___________________________________

Alternate 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
- ❑ Yellow Pages: Which Directory? _________________
- ❑ Web Page: Which website?_______________________
- ❑ Other: ___________________________________

Insurance/Payment Information

We ONLY accept Blue Cross Blue Shield, Allegiance, Medicare and Wyoming Medicaid

For all other insurances it will be the patients responsibility to submit for your reimbursement. Hole Family EyeCare will provide you with the proper invoices in order 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 EyeCare. Benefits quoted to the patient are based off of 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

Do you……(check box if your answer is yes)

- ❑ Work at a computer?
- ❑ Think you might benefit from thinner, lighter lenses?
- ❑ Have interest in a "test drive" of the latest contact lens designs
- ❑ Spend time outdoors? How much? __Hrs/week
- ❑ Have prescription sunwear?
- ❑ Prefer not to wear your glasses at times?
- ❑ Want information on Laser Vision Correction surgery?
- ❑ Have more than 1 pair of current Rx eyewear?
- ❑ 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?

Medications

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

____

____

____

Allergies to Medications? ☐Yes ☐No Please List: __________

____

Please complete other side ⟶

All of the information entered on this form is confidential and protected under HIPPA. Please fill out this case history as it is critical to the evaluation of your vision and health

Patient Medical History

Patient Height:________ ft. _________ in.

Patient Weight:________ lbs.

Blood Sugar: __________ mM

Name of Family Physician:_______________________________

Town:_______________________________________

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 surgeries? ❑Yes ❑No Please List:

____

____

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 (Musc.Dys., Osteoarthritis, Fibromyalgia)
❑ Cardiovascular (HTN, Heart Disease, Stroke)
❑ Gastrointestinal (Crohns, Colitis, Ulcer)
❑ Neurological (MS, Epilepsy, Alzheimer's, Parkinsons)
❑ 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? Please List:
____

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 either to myself or the party who accepts assignment of my claim. I authorize payment of medical benefits to the undersigned physicians or supplier for services provided.

Signature: ___________________________ Date: ___________

Patient Eye History

Date of last exam: _________________________________
By whom: _____________________________________

Have you ever experienced, been diagnosed or treated for any of the following: (Please check 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
❑Gritiness	❑Double Vision	❑Floaters/Spots

❑Retinal Detatchment ❑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

What kind? ________________________________

Solution: _________________________________

Are you satisfied with your vision and comfort of your contact lenses? ❑Yes ❑No

Would you like to try colored contact lenses if you aren't already wearing? ❑Yes ❑No

Are you satisfied with your current glasses? ❑Yes ❑No

If you wear bifocals or progressive lenses, do the lines or head tilting bother you? ❑Yes ❑No

Family Medical/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	❑ ____________________