HOLE Family Eye Care

WELCOME BACK TO OUR OFFICE

Today's Date: _____

Patient Demographics

Last Name: _____

First Name: _____ MI: _____

(please circle): Mr., Mrs., Miss. Age" _____

Birthdate: _____ SSN: _____

Ethnicity (please circle): Caucasian Hispanic
Asian African American

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?

_____

_____

It is the mission of the Hole Family EyeCare team to provide the highest quality of eyecare in both services and products. We will strive to promote visual excellence and preventative eye health, meanwhile helping each patient understand all aspects of their vision, in order to achieve the highest quality of life.

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 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 ——————►

Patient Medical History

Patient Height:_____ ft. _____ in.

Patient Weight:_____ lbs.

Blood Sugar: _____

Name of Family Physician:_____

City: _____

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)

If you are currently being treated for any of the above Please List:

_____

_____

All 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.

Family Medical/Eye History

Please 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	❑_____

Please Elaborate on any of the history checked above:

_____

_____

Thank you so much for taking the time to fill this form out, we know it may seem like an inconvenience but this information will allow us to perform a comprehensive eye exam.

I affirm that all 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: _____