HOLE Family Eye Care

WELCOME TO OUR OFFICE

Today's Date _____

Patient Information

(Circle one) Mr. Mrs. Ms. Miss Dr. Other_____
Last _____
First _____MI _____
Street _____
PO Box _____
City _____ State _____
Zip Code _____
Birthdate _____ Age Sex: M F
Employer _____
Patient's SSN _____
Home Phone _____
Cell/Work Phone _____
Email Address _____
Occupation_____
Spouse or Parent's Name_____
Spouse or Parent's Work _____
Spouse or Parent's Phone _____
(Please Circle Spouse or Parent)
Parent's Birthdate (if this is a child's visit)_____

What is the major purpose of this visit?

_____

Any problems with your current contact lenses or glasses?

_____

_____

VERY IMPORTANT!
Who may we thank for referring you to our office?
Name of friend or relative _____

If not referred, how did you choose our office?
❑ Another Dr.
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper/Radio/TV
❑ Yellow Pages: Which directory? _____
❑ Web Page: Which Web Site? _____
❑ Other _____

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 Information

We only accept Blue Cross/Blue Shield, P5, Medicare and Wyoming Medicaid.
(For all other insurances you will need to submit to them personally for your reimbursement. We will provide you with a superbill in order to do this.)

Please present your card to the front desk along with this completed form.

Please note that insurance does NOT cover the Contact Lens Follow-Up Evaluation.

How will you settle your account today?
❑ Cash/Check ❑ Credit Card ❑ Finance/Payment Plan

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.

For Blue Cross/Blue Shield, P5, Medicare and Wyoming Medicaid:
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 _____

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?

Continued on the other side --------→

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Name of Family Physician_____
Town_____
Date of Last Physical Check-up_____

CURRENT MEDICATIONS (Rx or Over the Counter)
(List name of medications including eye drops, vitamins, & birth control pills)_____
_____
_____
_____

Allergies to medications? ❑ Yes ❑ No
If so, what medications?_____
_____

Are you Pregnant or Nursing? ❑ Yes ❑ No
Have you had any surgeries? ❑ Yes ❑ No
Do you use cigarettes/tobacco, alcohol, or other substances? Please circle which ❑ Yes ❑ No

Have you ever been diagnosed or treated for the following health problems?

Allergies	❑	
Arthritis	❑	
Asthma	❑	
Blood/Lymph	❑	
Bronchitis	❑	
Cancer	❑	
Cholesterol	❑	
Diabetes	❑	Blood Sugar_____
Digestive	❑	
Ears/Nose/Throat	❑	
Endocrine	❑	
Eczema/Rashes	❑	
Fatigue	❑	
Fevers	❑	
Genitourinary	❑	
High Blood Pressure	❑	
Integumentary (Skin)	❑	
Kidney	❑	
Muscle/Bone	❑	
Neurological	❑	
Psychological	❑	
Respiratory	❑	
Sinus	❑	
Throat Infections	❑	
Thyroid	❑	Height _____
Unusual weight losses/gains	❑	Weight _____

Patient Eye History

Date of Last Eye Exam_____
By Whom?_____

Have you ever experienced, been diagnosed or treated for any of the following?

- ❑ Blurry Vision
- ❑ Burning
- ❑ Cataracts
- ❑ Corneal Abrasions
- ❑ Crossed eye/Eye turn
- ❑ Double Vision
- ❑ Eye Infections
- ❑ Eye Injury
- ❑ Flash of light
- ❑ Floaters/Spots
- ❑ Glaucoma
- ❑ Grittiness
- ❑ Headaches
- ❑ Iritis/Uveitis
- ❑ Itchiness
- ❑ Lazy Eye
- ❑ Macular Degeneration
- ❑ Occasional dryness
- ❑ Retinal Detachment
- ❑ Sunlight Sensitivity
- ❑ Tearing
- ❑ Trouble seeing at night
- ❑ Uncomfortable glasses
- ❑ Other eye disorders_____

Have you ever tried contact lenses? ❑ Yes ❑ No

Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____

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

Would you prefer clear contact lenses or colored contact lenses? ❑ Clear ❑ Colored

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

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following:
❑ No ❑ Yes (Please check boxes)

		Relationship
Blindness	❑	_____
Cataracts	❑	_____
Corneal Problems	❑	_____
Diabetes	❑	_____
Glaucoma	❑	_____
Heart Disease	❑	_____
Lazy Eye	❑	_____
Macular Degeneration	❑	_____
Retinal Problems	❑	_____

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