OFFICE USE ONLY	
Insurance	◯ Verified ◯ No Ins.
Dr. Signature	

PATIENT INFORMATION

Name (First, MI, Last)		**Preferred Name**
Date of Birth	**Gender** ◯ Male ◯ Female ◯ Other	**Social Security Number**
Address	**City/ State**	**Zip Code**
Phone ◯ Home ◯ Cell	**Email**	
Employer/Occupation	**Work Phone**	

DEMOGRAPHIC INFORMATION

Race
- ◯ American Indian or Alaska Native
- ◯ Asian
- ◯ Black or African American
- ◯ Hispanic or Latino
- ◯ Native Hawaiian/Pacific Islander
- ◯ White
- ◯ Declined to Specify

Ethnicity
- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Declined to Specify

Marital Status
- ◯ Never Married
- ◯ Married
- ◯ Domestic Partner
- ◯ Separated
- ◯ Divorced
- ◯ Interlocutory
- ◯ Widowed

Preferred Language
◯ English ◯ Spanish ◯ French ◯ ASL
◯ Other: ____________________________

Do you require an interpreter?
◯ Yes ◯ No

PRIMARY CARE PHYSICIAN INFORMATION

Name of PCP	**Practice/Clinic Name**	**Phone**
Address	**City/State**	**Zip Code**

HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have read and/or received Hollaway Eye Associates' Notice of Privacy Practices. I also understand that Hollaway Eye Associates partners with Luxottica (LensCrafters) to use the address, phone numbers and email addresses provided to remind patients of their appointments and that the phone call may be live or prerecorded. Only your name, address, phone number and email will be shared with LensCrafters for purposes of appointment reminders and scheduling of appointments only. No other information is shared without your express request and consent.

_______________________________________ _______________________

Patient/Guardian Signature **Date**

ACKNOWLEDGEMENT OF INSURANCE PRACTICES

I hereby assign my vision benefits to Hollaway Eye Associates, and authorize said assignee to release all information necessary to secure payment from my insurance company. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company, and that final determination can only be made when the claim is processed. I understand that if some fees are not paid by my insurance, I am still responsible and will be billed for them. Accounts 90 days-old are subject to collections. In order to control billing costs and reduce the need to raise our fees, all co-payments, deductibles, and charges for non-covered services are due at the time that they are rendered.

_______________________________________ _______________________

Patient/Guardian Signature **Date**

OCULAR HISTORY

Reason for today's visit	
Date of last eye exam	**Previous Eye Care Provider**
Current vision correction: ◯ Glasses ◯ Contact Lenses ◯ None	**If Contact Lenses, which type/brand?**

MEDICAL AND SOCIAL HISTORY

List all major surgeries and/or hospitalizations:	
Current medications, including vitamins and OTC medications *(You may provide a list, if necessary)*	
Do you have allergies to any medications? ◯ Yes: ____________________ ◯ No	**Do you have any allergic sensitivities?** *(latex, hay fever, etc.)* ◯ Yes: ____________________ ◯ No
Recent tetanus shot? *(within 10 years)* ◯ Yes ◯ No	**Pregnant/Nursing?** ◯ Yes ◯ No
Do you use tobacco products? *(If yes, how often?)* ◯ Yes ◯ No	**Do you drink alcohol?** *(If yes, how often?)* ◯ Yes ◯ No
Do you use controlled substances? *(If yes, what and how often?)* ◯ Yes ◯ No	**Have you ever been exposed to or infected with:** ◯ Gonorrhea ◯ Hepatitis ◯ HIV ◯ Syphilis ◯ None of the above

DO YOU CURRENTLY HAVE ANY OF THESE PROBLEMS?

General:	Fever	Weight Loss	Weight Gain	Fatigue
Ear, Nose, Throat:	Allergies	Sinus Problems	Cough	Dry Mouth
Cardiovascular:	High BP	Heart Surgery	Vascular Disease	
Respiratory:	Asthma	Bronchitis	Emphysema	COPD
Genital, Kidney, Bladder:	Kidney Stones	Frequent Urination	Impotence	
Muscles, Bones, Joints:	Arthritis	Joint Pain	Head or Neck Injury	
Skin:	Growths	Rashes	Acne	
Neurological:	Headaches	Migraines	Seizures	
Psychiatric:	Depression	Anxiety	Insomnia	
Endocrine:	Thyroid	Diabetes		
Blood/Lymph:	Anemia	Cholesterol	Bleeding	
Allergic/ Immunologic:	Seasonal Allergies	Rheumatoid	AIDS	Lupus
Gastrointestinal:	Diarrhea	Constipation	Ulcer	Reflux

OCULAR SYSTEMS

Vision Loss	Blurred Vision
Double Vision	Dryness
Itching	Burning
Light Sensitivity	Eye Pain
Flashes	Floaters/Spots
Redness	Discharge
Sties/Chalazion	Sandy/Gritty Feeling
Foreign Body Sensation	Macular Degeneration
Cataracts	Retinal Detachment
Retinal Degeneration	Crossed/Lazy Eye
Glaucoma	Tearing/ Watering
Eye Injuries	Color Blindness
Eye Infection	Other

DO ANY OF YOUR IMMEDIATE FAMILY MEMBERS HAVE A HISTORY OF ANY OF THE FOLLOWING?

(Indicate which family member)

Cancer	High Blood Pressure	Diabetes	Cholesterol	Retinal Detachment
Cataracts	Glaucoma	Blindness	Macular Degeneration	Crossed/Lazy Eyes