Holicki Eye Centers and Holicki Optical Patient Information

LEGAL FIRST AND LAST NAME:_____

DATE OF BIRTH: _____ SOCIAL SECURITY # :_____-_____-_____ GENDER: MALE OR FEMALE

ADDRESS: _____ CITY :_____

STATE: _____ ZIP_____ HOME PHONE: ( )_____ CELL PHONE: ( )_____

MARITAL STATUS: SINGLE | MARRIED | WIDOWED | DIVORCED

EMPLOYER:_____ OCCUPATION:_____ PHONE: ( )_____

EMAIL ADDRESS:_____@_____

PHARMACY NAME:_____ CITY:_____ PHONE: ( ) _____

PRIMARY CARE DOCTOR:_____ CITY:_____ PHONE: ( )_____

EMERGENCY CONTACT:_____ RELATIONSHIP:_____ PHONE: ( ) _____

Occasionally, on your behalf and with your permission, it is necessary for us to disclose or share your Protected Health Information with another person(s) Please specify the individual(s) and the protected health information that can be shared. This permission can be rescinded at any time if provided in writing.

____ NONE (Do not share my information) ____ ALL INFORMATION ____ ONLY SPECIFIC INFORMATION_____

NAME:_____ RELATIONSHIP_____ PHONE #:_____

Card Holder or Responsible Party (if other than patient)

Name:_____ Social Security #: _____-_____-_____ Date of Birth: _____

Relationship to patient:_____ Address:_____ City:_____

State:_____ Zip:_____ Phone: ( )_____

Employer:_____ Address:_____ City:_____

State:_____ Zip:_____ Work Phone #: ( ) _____

PRIMARY INSURANCE_____ NAME OF INSURED_____

SUBSCRIBER ID_____ GROUP NUMBER_____

SECONDARY INSURANCE_____ NAME OF INSURED_____

SUBSCRIBER ID_____ GROUP NUMBER_____

*I acknowledge that I have been offered a copy of the Notice of Privacy Practices (HIPPA) for Holicki Eye Centers and Holicki Optical. It provides information about how we may use and disclose protected health information about you. This is in compliance with the Health Insurance Portability and Accountability Act of 1996.

PATIENT SIGNATURE (OR RESPONSIBLE PARTY):_____ DATE:_____

PATIENT MEDICAL INFROMATION

DATE: ____/____/_____ LEGAL NAME: _____ DATE OF BIRTH: _____

*** Age of current glasses?** _____ *** Who should we contact for your oldest glasses prescription?** _____

* Do you have an Advanced Directive / Living will? YES or NO * Do you have a Health Care Proxy? YES or NO

Medical History:	**YES**	**NO**
DIABETES		
Doctor: _____		
Last Blood Sugar: _____ HgbA1C: _____		
Anxiety		
Arthritis		
Asthma		
Atrial Fibrillation		
BPH: Enlarged Prostate		
Cancer: Type:_____		
Congestive Heart Failure		
COPD		
Coronary Artery Disease		
Dementia		
Erectile Dysfunction		
GERD		
Hearing Loss		
Heart Attack		
Hepatitis: A ☐ B ☐ C ☐		
Herpes		
HIV /AIDS		
Hypercholesterolemia/ High Cholesterol		
Hypertension/ High Blood Pressure		
Hyperthyroidism		
Hypothyroidism		
Leukemia		
Lymphoma		
Multiple Sclerosis		
Myasthenia Gravis		
Neuropathy		
Parkinsons		
Polycystic Ovarian Syndrome		
Renal Failure		
Rheumatoid Arthritis		
Rosacea		
Sarcoidosis		
Seizures		
Shingles		
Sjogrens Syndrome		
Stroke		
Tuberculosis		
Other:		
Other:		

Ocular Surgery:

NONE: ☐	**YES**	**NO**	**RT**	**LT**
Cataract Surgery				
Laser: What type:_____				
Eye Muscle/ Eyelid Surgery				
Retinal / Injections				
LASIK /PRK / RK				
Retinal / Glaucoma Laser				
Other:				

Ocular History / Diagnosis:

NONE: ☐	**YES**	**NO**	**RT**	**LT**
Cataract				
Corneal Dystrophy				
Diabetic Retinopathy				
Dry Eyes				
Floaters				
Glaucoma / Ocular Hypertension				
Macular Degeneration				
Narrow Angles				
Amblyopia / History of Patching				
Double Vision				
Retinal Detachment or Tear				
Other:				

Family History:	**YES**	**NO**	**WHO?**
Cancer			
Stroke			
Diabetes			
Glaucoma			
Heart Disease			
Hypertension			
Macular Degeneration			
Retinitis Pigmentosa			
Strabismus /Eye Muscle Misalignment			

Tobacco Use: ☐ Never ☐ Former ☐ Current User		
Daily Alcohol Use: ☐ None ☐ Less than 1 ☐ 1-2 ☐ 3 or more		
Pneumonia Vaccine: Year Given:_____	YES	NO
Flu Vaccine: Date: _____	YES	NO
Covid Vaccine: Date: _____	YES	NO

LEGAL NAME: _____ **D.O.B.** _____

Allergies: List ALL Allergies: **None:** ☐

Past Surgical History: List All Surgeries **None:** ☐

Medications: **None:** ☐

Include Over the Counter, Prescription and Recreational

Date: _____ **Patient Signature:** _____