

Welcome to Dr. Doyle D. Holle's Total Eyecare Center, PC

****PLEASE HAVE YOUR MEDICARE AND INSURANCE CARDS READY FOR US TO PHOTOCOPY****

Date: _____ Email: _____

Patient: _____
first middle initial last

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: H _____ W _____ C _____

Student: Full or Part-time Marital Status: M S D W

Birthdate: _____ Sex: M F

Social Security No. _____

Occupation: _____

Employer: _____

RESPONSIBLE PARTY INFORMATION

Name: _____
first middle initial last

Str. Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Birthdate:: _____ Sex: M F

S.S. #: _____

Employer: _____

Relationship to patient: _____

Who referred you to our office? _____

PLEASE CHECK THE VISION BENEFIT PLAN THAT YOU HAVE

VSP VCDIRECT EYEMED VISION ONE AARP COAST2COAST BCBS SVP

Cardholder's Name: _____
first middle initial last

Cardholder's SS#: _____

FINANCIAL AGREEMENT

ACKNOWLEDGE FULL RESPONSIBILITY FOR ALL CHARGES INCURRED EVEN IF MY INSURANCE LATER DETERMINES MY SERVICES TO BE NON-COVERED OR NOT A BENEFIT. THIS MAY INCLUDE ANY ADDITIONAL CHARGES INCURRED IN THE COLLECTION OF THIS ACCOUNT. THE FINANCIAL POLICY OF THIS PRACTICE HAS BEEN FULLY EXPLAINED TO ME.

Patient Signature: _____

RELEASE OF INFORMATION

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I can revoke these at any time, by informing the Privacy Officer in writing.

Home or cellular telephone numbers: We may leave a message with a call back number or a reminder of your appointment on your voicemail.

Work telephone numbers: We may leave a message with a call back number or a reminder of you appointment on voicemail.

Written communication: We may mail postcards to your home address or send you an email.

Patient Signature: _____ Date: _____

Name of your family physician: _____ Phone: _____

YOUR HEALTH HISTORY:

Please **circle yes (Y)** below if **YOU** currently have any of the following or **no (N)** if you do not.

ALLERGY / IMMUNOLOGY:

- Y N Allergies / Hayfever
- Y N Rheumatoid Arthritis
- Y N Lupus

CARDIOVASCULAR:

- Y N Heart Pain (angina)
- Y N Rapid or irregular heart beat
- Y N High blood pressure
- Y N Valve disease
- Y N Coronary artery disease

CONSTITUTIONAL / GENERAL:

- Y N Fever within last month
- Y N Chronic fatigue
- Y N Significant weight loss
- Y N Trauma

EARS, NOSE, MOUTH, THROAT:

- Y N Hearing loss
- Y N Ringing in ears
- Y N Sinus problems / congestion
- Y N Frequent cold sores
- Y N Dry throat or mouth

ENDOCRINE:

- Y N Diabetes Type 1 or Type 2
- Y N Hyper / Hypo Thyroid Disease
- Y N Hormonal Replacement Therapy

GASTROINTESTINAL:

- Y N Nausea / Vomiting
- Y N Heartburn or Hiatal hernia
- Y N Ulcers or bleeding
- Y N Diarrhea or Constipation

GENITOURINARY:

- Y N Frequent urination
- Y N Frequent night urination
- Y N Kidney problems
- Y N Pregnant or Nursing NOW

HEMATOLOGIC/LYMPHATIC

- Y N Enlarged lymph glands/ nodes
- Y N Bleeding disorder
- Y N Anemia
- Y N High cholesterol
- Y N HIV/AIDS
- Y N Leukemia or blood cancer
- Y N Sickle Cell Disease
- Y N Accident related large loss of blood

SKIN:

- Y N Skin Rashes, Dermatitis
- Y N Acne Rosacea
- Y N Psoriasis
- Y N Basal cell, Squamous, Melanoma

MUSCULOSKELETAL:

- Y N Polymyalgia Rheumatica
- Y N Lupus
- Y N Osteoporosis
- Y N Rheumatoid Arthritis
- Y N Osteoarthritis

NEUROLOGICAL:

- Y N Frequent headaches
- Y N Migraines
- Y N Dizziness or fainting
- Y N Numbness or tingling
- Y N Seizures, convulsions, epilepsy
- Y N Blacked-out or lost consciousness
- Y N Stroke or TIA

PSYCHIATRIC

- Y N Anxiety
- Y N Memory loss
- Y N Depression
- Y N Mental illness

RESPIRATORY:

- Y N Asthma / Emphysema
- Y N Tuberculosis
- Y N Chronic Bronchitis

LIST ALL MAJOR ILLNESSES, INJURIES AND SURGERIES

Problem or Procedure	Year	Physician
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

CURRENT MEDICATIONS AND SUPPLEMENTS AND EYE DROPS:

- 1. _____ 3. _____ 5. _____
- 2. _____ 4. _____ 6. _____

ALLERGIES/SENSITIVITY TO ANY MEDICATIONS OR SUBSTANCES

- 1. _____ 3. _____ 5. _____
- 2. _____ 4. _____ 6. _____

Do you now wear contacts regularly? Yes No If yes, are they Hard / Rigid or Soft.

If you wear contact lenses, please list your contact lens prescription below:

Right eye Base Curve _____ Power _____ Cylinder _____ Axis _____ Diameter _____ Name _____

Left eye Base Curve _____ Power _____ Cylinder _____ Axis _____ Diameter _____ Name _____

Optomap Retinal Exam

(Alternative to Pupil Dilation)

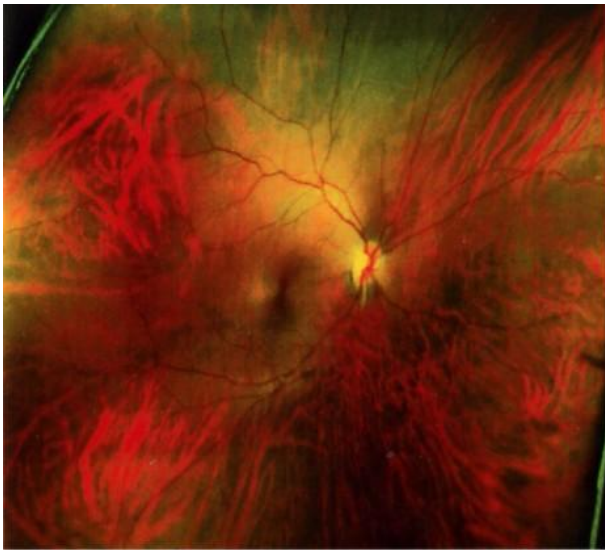
The **Optomap Digital Retinal Scan** captures and analyzes an image of virtually the entire retina, without the need for pupil dilation, for the early detection and management of eye disease.

Dr. Doyle Holle is concerned about retinal problems including macular degeneration, glaucoma, retinal holes or detachments, and systemic diseases such as diabetes, stroke, and high blood pressure. These conditions can lead to serious eye health problems, including partial loss of vision or blindness and often develop without warning and progress with no symptoms.

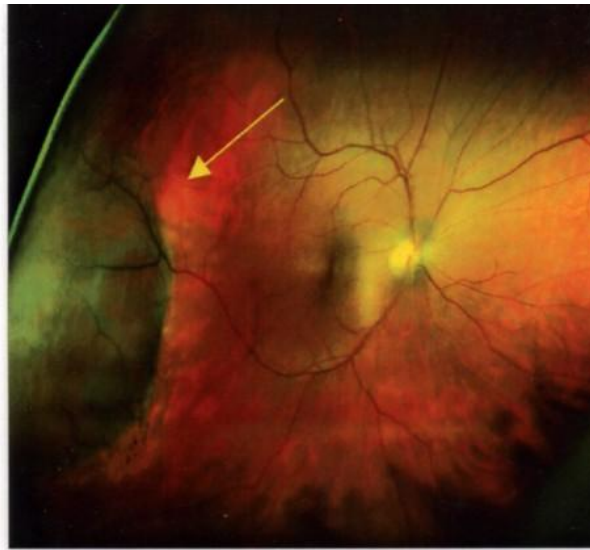
An **Optomap Digital Retinal Scan** provides:

- 1) An eye wellness scan
- 2) An in depth view of the retinal layers (where disease can start)
- 3) The ability for you to view your Optomap Digital Retinal Scan with Dr. Holle during your exam
- 4) A yearly, permanent record for your medical file, which gives Dr. Holle a baseline for future comparisons of "unusual but normal finding" and the tracking and diagnosing potential eye disease.

The **Optomap Digital Retinal Scan** is fast, easy and comfortable.



Healthy Retina



Unhealthy Retina

Insurance typically does not cover any advanced screening technology beyond the general eye exam.

Dr. Doyle Holle strongly recommends the Optomap Digital Retinal Scan once a year for all patients.

Please choose one of the following:

- I would like to have the **Optomap Digital Retinal Scan** for \$32.00.
- I prefer to get my eyes dilated today. I understand that my vision will be blurry for 2 hours and I will be very sensitive to light for 4 hours.
- I prefer Dr. Holle to choose (Optomap or Dilation) based on what he feels would be the best for me.

Signature

Date