EYE & FACIAL
PLASTIC SPECIALISTS
Dr. Donald Hollsten & Dr. Jordan Hollsten

New Patient Information for Minor Patients

PATIENT INFORMATION

Last Name _____ **First Name** _____ **MI** _____
(circle one) Jr. Sr. Other **(circle one)** M F **Nickname** _____
Date of Birth _____ **SSN** _____
Mailing Address _____ **Suite/Apt.** _____
City _____ **State** _____ **Zip** _____
Email _____ **Preferred Language** _____
Home Phone _____ **Cell Phone** _____
Emergency Contact _____ **Emergency Phone** _____
Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION (if patient is a minor)

Last Name _____ **First Name** _____ **MI** _____
(circle one) Jr. Sr. Other **(circle one)** M F **Nickname** _____
Date of Birth _____ **SSN** _____
Mailing Address _____ **Suite/Apt.** _____
City _____ **State** _____ **Zip** _____
Home Phone _____ **Cell Phone** _____
Relationship to Patient _____

PRIMARY INSURANCE DETAILS ☐ **Check this box if Patient details are the same as Guarantor**
Insurance _____ **Subscriber ID #** _____ **Group #** _____
Claims Address (on back of card): **Street** _____
City/State/Zip _____

(Please fill out with information of Primary Guarantor if different from patient)

Last Name _____ First Name _____ MI _____
Mailing Address _____ Suite/Apt. _____
City _____ State _____ Zip _____
Phone Number _____
Date of Birth _____ SSN _____

SECONDARY INSURANCE DETAILS ☐ **Check this box if Patient details are the same as Guarantor**
Insurance _____ **Subscriber ID #** _____ **Group #** _____
Claims Address (on back of card): **Street** _____
City/State/Zip _____

(Please fill out with information of Secondary Guarantor if different from patient)

Last Name _____ First Name _____ MI _____
Mailing Address _____ Suite/Apt. _____
City _____ State _____ Zip _____
Phone Number _____
Date of Birth _____ SSN _____

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OFFICE POLICIES

I understand the following:

- ➔ CO-PAYMENT/deductible is due at the time of the appointment.
- ➔ I acknowledge financial responsibility for any balance(s) not paid by my insurance, including deductibles, co-payments, co-insurance, and/or any non covered service(s), etc; failure to comply could result in a collection debt.
- ➔ A $50 non-refundable fee will be accessed for failure to show for a scheduled appointment without notifying Dr. Hollsten's office at least 24 hours in advance.
- ➔ I authorize release of all information necessary to secure insurance payment.
- ➔ Any missing or incorrect information might result in problems with insurance companies. In those cases, I am responsible for the full payment.
- ➔ I acknowledge I have provided the most accurate and current information to the best of my knowledge.

SIGNATURE _____ **DATE** _____

PATIENT MEDICAL HISTORY

Referring Physician _____ OR **Other Referral** _____

Primary Care Physician _____ **Cardiologist** _____

Ear/Nose/Throat

- ❑ Hearing Loss
- ❑ Sinus Problems
- ❑ Sore Throat
- ❑ Other _____

Heart Issues

- ❑ Chest Pain
- ❑ Irregular Heartbeat
- ❑ Heart Attack
- ❑ Other _____

Urinary Issues

- ❑ Pain or Discomfort
- ❑ Blood in Urine
- ❑ Other _____

Skin Problems

- ❑ Excessive Dryness
- ❑ Other _____

Musculoskeletal Issues

- ❑ Muscle Aches
- ❑ Joint Pain
- ❑ Swollen Joints
- ❑ Other _____

Psychiatric Issues

- ❑ Depression
- ❑ Anxiety
- ❑ Other _____

Respiratory Issues

- ❑ Asthma
- ❑ Shortness of Breath
- ❑ Coughing
- ❑ Other _____

Gastrointestinal Issues

- ❑ Heartburn
- ❑ Belly Pain
- ❑ Diarrhea
- ❑ Other _____

Neurological Issues

- ❑ Numbness
- ❑ Weakness
- ❑ Headaches
- ❑ Paralysis
- ❑ Other _____

Miscellaneous

- ❑ High Blood Pressure
- ❑ Cancer _____
- ❑ Immune System Disorder
- ❑ Thyroid Disease
- ❑ Stroke
- ❑ Bleeding Disorder
- ❑ Hyperlipidemia
- ❑ Diabetes
- ❑ _____

Have you ever been diagnosed with any of the following eye conditions? *(check all that apply)*

☐ Glaucoma ☐ Wandering Eye ☐ Droopy Eyelid

☐ Cataract ☐ Detached Retina ☐ Other _____

PATIENT SURGICAL HISTORY

Procedure _____ Date_____

Procedure _____ Date_____

Procedure _____ Date_____

Procedure _____ Date_____

*List additional Procedures on the back of this page

ALLERGIES

Food	Yes	No	_____
Medicine	Yes	No	_____
Environmental	Yes	No	_____

SMOKING HISTORY Never Current Former

ALCOHOL USE Number of Drinks Per Day _____ Number of Drinks Per Week _____

FAMILY MEDICAL HISTORY (*Check all that apply)*

☐ Diabetes	Family Member _____
☐ High Blood Pressure	Family Member_____
☐ Cancer	Family Member _____
☐ Stroke	Family Member _____
☐ Bleeding Disorder	Family Member _____
☐ Asthma	Family Member _____
☐ Immune System Disorder	Family Member _____
☐ Other _____	Family Member _____

SIGNATURE _____**DATE** _____