



**EYE & FACIAL  
PLASTIC SPECIALISTS**

Dr. Donald Hollsten & Dr. Jordan Hollsten

## New Patient Information

### **PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Gender (circle one) Male Female Non-Binary Prefer not to say

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

Marital Status (circle one) Single Married Divorced Widowed Partner

Mailing Address \_\_\_\_\_ Suite/Apt. \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Preferred Language \_\_\_\_\_ Email \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Preferred Method of Communication (circle one) text voicemail home voicemail cell email

Preferred Pharmacy Location \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Emergency 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 \_\_\_\_\_

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 \_\_\_\_\_

Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_

### **REFERRAL INFORMATION**

Referring Physician \_\_\_\_\_ OR Other Referral \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Cardiologist \_\_\_\_\_



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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.
- I understand that visual field exams will not be performed on the same day as an office visit exam.
- 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.
- A \$150 non-refundable fee will be accessed for failure to show for a scheduled surgery without notifying Dr. Hollsten's office at least 2 weeks 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

## 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-PLEASE LIST**

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** \_\_\_\_\_



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## Medication List

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

| MEDICATION | DOSE  | FREQUENCY |
|------------|-------|-----------|
| 1. _____   | _____ | _____     |
| 2. _____   | _____ | _____     |
| 3. _____   | _____ | _____     |
| 4. _____   | _____ | _____     |
| 5. _____   | _____ | _____     |
| 6. _____   | _____ | _____     |
| 7. _____   | _____ | _____     |
| 8. _____   | _____ | _____     |
| 9. _____   | _____ | _____     |
| 10. _____  | _____ | _____     |
| 11. _____  | _____ | _____     |
| 12. _____  | _____ | _____     |
| 13. _____  | _____ | _____     |
| 14. _____  | _____ | _____     |
| 15. _____  | _____ | _____     |