**Drs. Holcomb & Associates**

**“Live well. See well.”**

**Patient Information:**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 First MI Last

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male Female Cell Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other household members who are patients here \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Last eye exam date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last medical exam date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dr.’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check any of the following that apply to you or your family:

 You Family You Family You

Diabetes Pregnant Blur at a distance

High blood pressure Sinus trouble Blur when reading

Heart problems Asthma Double vision

Thyroid problems Allergies Spots/floaters

Lung problems Retinal detachment/disease Distorted vision/halos

Arthritis Macular degeneration Flashes of light

Cancer Eye Surgery Computer eye strain

HIV positive Cataracts Glare

Kidney disease Glaucoma Burning/stinging/itching

Lupus Eye injury Dry or Gritty eyes

Headaches Temporary loss of vision Tearing

Migraines Blindness Mucous discharge

Seizures Crossed or lazy eyes Redness

Vascular disease Loss of side vision Eye infection

Please list any medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had your eyes dilated? Yes No Any adverse reaction? Yes No

Do you currently wear glasses? All the time Distance only Reading/near work Computer work Work Safety

Have you ever worn contact lenses? Yes No Do you wear them currently? Yes No If so, how old are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you work at a computer? Yes No If yes, how many hours daily? \_\_\_\_\_\_\_\_\_\_ Do you need safety eyewear? Yes No

In what hobbies or sports do you participate in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE TURN THIS SHEET OVER TO COMPLETE THE INFORMATION**

**Contact Lens Policy:** In addition to the annual comprehensive eye exam, the contact lens exam fee includes the evaluation of the best lens options and best fit for your personal needs, as well as progress evaluations, and changes or refits for **ninety (90) days** from the exam date. **Fitting fees are nonrefundable.** Upon completion of the fitting process, contact lens prescriptions are legally valid for **one year** from the finalization date.

By signing below, you acknowledge that:

* Monovision patients may experience decreased depth perception while driving.
* You are comfortable with insertion, removal, and care of your contact lenses.
* You agree to clean, disinfect, and dispose of your lenses according to the care regimen prescribed by your doctor and explained by the dispensing staff.
* You agree to discontinue wearing the contact lenses and seek professional help if you notice:
	+ Persistent redness, irritation or discomfort
	+ Decreased vision while wearing lenses
	+ Eye pain and/or light sensitivity

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Age-Related Macular Degeneration (Ages 50 and Up) Risk and Symptom Assessment:** Age-Related Macular Degeneration is the leading cause of vision loss among older Americans. It is a progressive condition that causes a part of your retina called the Macula to deteriorate with age. The macula is responsible for your central vision, which allows you to do things like read, watch TV, recognize faces and drive. You are more at risk for AMD if you are more than 50 years old, are a current or past smoker, are overweight, have heart disease, high blood pressure and/or high cholesterol, have a family history of AMD, or are Caucasian (white).

Please check any symptoms of AMD that apply to you:

 Difficulty seeing at night Difficulty driving at night Distorted / blurry vision Difficulty reading in dim light Recent changes in vision

**Dry Eye Risk and Symptom Assessment:** Dry Eye Disease is a common condition caused by a disrupt in the tear film of your eyes. As a result, your tears are not able to provide enough lubrication for your eyes. Reasons for a disrupt in normal tear film can include hormone imbalances, autoimmune diseases, increased tear evaporation, inflammation in the body, allergic eye disease, certain medications, LASIK eye surgery, aging and more. Symptoms will usually affect both eyes. Please check any symptoms of Dry Eye Disease that apply to you:

 Stinging, burning, or scratchy sensation in the eyes Watery eye(s) Eye redness Stringy mucous in or around eye(s)

 Difficulty wearing contact lenses A sensation of having something in your eye(s)

**Insurance Information:**

Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_

Vision Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Member ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 of SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization:** I authorize the release of any medical information necessary to my family or caregivers, referring or family physicians, or to process a claim to any insurance company. I hereby assign to and authorize directly to Drs. Holcomb and Associates all benefits payable under such insurance policy. I realize that the insurance my not pay my entire bill, and I agree to pay the difference or the entire bill if necessary. I agree that Drs. Holcomb and Associates and/or its agents, in order to service my account or collect monies I may owe, may contact me by telephone at any number associated with my account, including wireless telephone numbers which could incur usage charges. I also agree that I may be contacted through text messages or emails, using any email address I provide.

I have read this disclosure and agree that Drs. Holcomb and Associates, its employees and/or agents may contact me as described above.

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledgement of Receipt of Privacy Statement**

By signing below, I am acknowledging that:

* I am either the patient or the patient’s personal representative.
* I have received a copy of the “Notice of Privacy Practices for Drs. Holcomb & Associates”.
* I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Patient or Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_