Holland Eye Surgery & Laser Center ● 999 Washington Ave ● Holland, MI 49423

Name (as appears on Insurance): _____
First Middle Int. Last

Nickname: _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Social Security #:** _____

Primary Phone #:(_____)_____ □Cell □Home □Work □Other_____

Secondary Phone #:(_____)_____ □Cell □Home □Work □Other_____

Sex: □ Male □ Female **Race:** _____ **Ethnicity:** _____

E-Mail Address: _____ **Marital Status:** □ Single □ Married □ Divorced □ Widowed

Primary Care Physician: _____ **Referring Doctor:** _____

Preferred Pharmacy: _____ **Pharmacy Address:** _____

Occupation: _____ **Employer:** _____

Spouse's Name: _____ **Spouse's Phone #:** _____

Release of medical information: Please list anyone who may receive medical information about you. Include anyone who may answer your phone and with whom we may leave a message for you (i.e., spouse, child, or parent). Please also indicate if this person may be considered an emergency contact.

Name	Relationship	Phone #	Emergency Contact?
			□Yes □No
			□Yes □No

Holland Eye Surgery & Laser Center may use and disclose Protected Health Information about me to carry out treatment, payment, and healthcare operations.

Holland Eye Surgery & Laser Center may contact me by mail, phone, or email with regards to appointment registration and reminders, healthcare information, billing, and patient satisfaction feedback. The contact information provided above will be used when relevant for these purposes.

I acknowledge the receipt of the Notice of Privacy Practices.

I understand that Holland Eye Surgery & Laser Center will file a claim with my medical insurance on my behalf for services rendered, and that I am responsible for any copays and personal balances due according to my insurance plan. If I do not have medical insurance, I am responsible for the full balance due.

_____ _____
Signature **Date**

HOLLAND EYE SURGERY & LASER CENTER

Eric D. Snyder, MD
Benjamin D. Currie, MD
Tara M. Oosterbaan, OD
Rosanne M. Pruis, OD
Kelly M. James, OD

MEDICAL HISTORY QUESTIONAIRE

Name: _____ Date of birth: _____

Past Ocular History:	**Y**	**N**	**Explanation:**
Eye Injuries	☐	☐	Type, eye, and date:
Cataracts	☐	☐	If removed, date and doctor:
Glaucoma	☐	☐	If yes, year diagnosed:
Crossed/lazy eyes (please circle)	☐	☐	If yes, which eye:
Eye Surgeries	☐	☐	Type, eye, and date:
Do you wear contact lenses?	☐	☐	**Circle:** Hard lenses Soft lenses Years:____

Current Medical Conditions:	**Y**	**N**	**Explanation**
Diabetes	☐	☐	☐ Type I ☐ Type II Year diagnosed_____ A1C level_____ Date done_____
Thyroid disorders	☐	☐	Type:
Heart disease	☐	☐	
Are you pregnant or nursing?	☐	☐	
Cancer	☐	☐	Type: Year diagnosed:
High blood pressure	☐	☐	
Stroke	☐	☐	Right Side ☐ Left Side ☐ Year:
Shortness of Breath/Asthma/ Emphysema/COPD (please circle)	☐	☐	
Neurological disorders	☐	☐	Type:
Psychological disorders	☐	☐	Type:
High cholesterol	☐	☐	
Other			

SEE NEXT PAGE

PATIENT NAME:_____**DATE OF BIRTH**_____

Current Medications: name and strength (mg), including over the counter medications

Example: Lisinopril 20 mg, Aspirin 81 mg

_____ _____ _____

_____ _____ _____

_____ _____ _____

Check if you are taking any of these medications (including brand names of these generic medications):

☐ **Amiodarone**	☐ **Hydroxychloroquine**	☐ **Chloroquine**
☐ **Leflunomide**	☐ **Tamoxifen**	☐ **Perphenazine**
☐ **Prochlorperazine**	☐ **Fluphenazine**	☐ **Chlorpromazine**
☐ **Trifluoperazine**	☐ **Thioridazine**	

Eye Medications:

_____ _____ _____

Allergies: Medication name and <u>REACTION:</u>

_____

_____

Surgical History of: Heart Head Brain Lung Neck with dates:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family Ocular History: Y N Relation

Retinal Detachment	☐	☐	
Macular Degeneration	☐	☐	
Glaucoma	☐	☐	

Social History:

Do you smoke? ☐ Yes ☐ No If yes, how much? _____ How many years?_____

If you quit smoking, when? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Have you fallen within the last year? ☐ Yes ☐ No

FOR OFFICE USE ONLY:
Reviewed by:
_____ _____
Doctor's Signature Date