WELCOME TO THE HOLLYWOOD VISION CENTER – Optometry & Homeopathy

Date_____

Patient_____ Age_____ Date of Birth_____

Home Address_____City_____Zip_____

Home Phone ( ) _____ Cell Phone ( )_____

Employer_____ Occupation_____

Business Address_____ Business Phone ( )_____

D. L. State & #_____ SS#_____ E-Mail **_____

Spouse's Name_____ Employer_____

Business Phone_____ **Referred By**_____

** We kindly request an email address to remind you when it's time for your annual exam, and when your glasses or contact lenses are ready. Due to medical privacy laws, we will not share this with anyone. **

MEDICAL HISTORY

Date of last vision exam_____ Previous Eye Doctor_____

Past injury or surgery to eyes? --Select--

Please Describe: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury?_____

Have you had a physical exam in the last 12 months? --Select--

Physician's Name_____

Please describe if there were any significant findings_____

List any medications you are taking, reason, and start date _____

_____

Are you allergic to any medications? If yes, please list_____

Do you drive? --Select-- Do you have visual difficulty when driving? --Select--

If yes please describe:

_____

Please list an emergency contact who is not living with you:

Name:_____ Phone:_____ Relationship:_____

FAMILY and HEALTH HISTORY

Please note any personal or family history (parents, grandparents, siblings; living or deceased) for the following conditions:

CONDITION	YES	NO	Details	RELATIONSHIP TO YOU
Blindness	○	○		
Cataracts	○	○		
Crossed Eyes	○	○		
Glaucoma	○	○		
Macular Degeneration	○	○		
Retinal Detachment/Disease	○	○		
Cancer (list type)	○	○		
CONDITION	YES	NO		RELATIONSHIP TO YOU
Accident/Head Trauma (list type, year)	○	○		
CARDIOVASCULAR: (high blood pressure, hypercholesterolemia, etc.)	○	○		
NEUROLOGICAL (Stroke, aneurysm, numbness, headache, seizures, neurosurgery, paralysis, etc.)	○	○		
ENDOCRINE (diabetes, hypothyroid, hyperthyroid, etc.)	○	○		
ALLERGIC/IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)	○	○		
SKIN (cancer, rosacea, dryness, eczema, psoriasis, growths, rash, etc.)	○	○		
PSYCHIATRIC (anxiety, depression, insomnia)	○	○		
RESPIRATORY (congestion, wheezing, shortness of breath, etc.)	○	○		

GASTROINTESTINAL (Crohn's, ulcers, hernia, etc.)	◯	◯		
BLOOD/ LYMPH (bleeding, anemia, problems related to blood transfusion, etc.)	◯	◯		
GENITAL, KIDNEY, BLADDER (painful or frequent urination, kidney disease, yellow jaundice, etc.)	◯	◯		
FEMALES: Are you pregnant or nursing?	◯	◯		
MUSCLES, BONES, JOINTS (arthritis, joint pain, swelling, cramps, etc.)	◯	◯		
EARS, NOSE, THROAT (hard of hearing, dry mouth, etc.)	◯	◯		
Smoking tobacco	◯	◯		
Other	◯	◯		

ACCOUNT RESPONSIBLE

Payment is expected when services are rendered, unless other arrangements are made in advance. We do NOT bill patients or their insurance companies. The amount paid to you is related to the amount of insurance coverage that you have purchased. These benefits are specified in your contract, and bear no relationship to the value of our services.

There is a 1½ % monthly service charge for balances after 30 days. The patient is responsible for any legal and related expenses involved in the collection of past due accounts.

Credits on materials are issued as store credits only. There are no credits on custom or prescription items. There is a restocking fee for any returned materials. There is a charge for additional tests and contact lens evaluation.

There are additional fees for contact lens evaluations and follow up visits.

There is a $35.00 late cancellation fee for appointments that are changed or canceled within 48 hours of your appointment time.

Method of payment: Self ◯ Parent ◯ Business Manager ◯

Vision Insurance and group number: _____

Name, Date of birth, and Social Security number for Primary Insured: _____

_____

Signature of person responsible for payment: _____ Date:_____

Please EM forms to: hollywoodvisioncenter@totalvisionllc.com 11.19