DONALD HOLLSTEN, M.D. ▫ JORDAN HOLLSTEN, M.D.
7950 Floyd Curl Drive
Suite 702
San Antonio, TX 78229
P: 210.616.0739 www.drhollsteneyes.com F: 210.616-0972

# New Patient Information

Date _____

**PATIENT INFORMATION**

**Last Name** _____ **First Name** _____ **MI** _____

**(circle one)** Dr. Mr. Mrs. Ms. Other **(circle one)** Jr. Sr. Other **Nickname** _____

**Street Address** _____ **Suite/Apt.** _____

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

**Email** _____

**Home Phone** _____

**Cell Phone** _____

**Alt. Phone** _____

**Date of Birth** _____ **SSN** _____

**Marital Status (circle one)** Single Married Divorced Widowed Partner **Sex** M F

**Referring Physician** _____

**Primary Care Physician** _____

**Cardiologist** _____

**Emergency Contact** _____ **Emergency Phone** _____

I understand the following:

- ➔ CO-PAYMENT is due prior to appointment.
- ➔ I am financially responsible for any balance not paid by my insurance, including deductibles, co-payments, co-insurance, etc.
- ➔ I will be charged a $50 non-refundable fee if I fail to show for a scheduled appointment without notifying Dr. Hollsten's office at least 24-48 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 providers. In those cases I am responsible for the full payment.
- ➔ An insurance provider returning unpaid claims to our office due to incorrect information as I provided in these forms is not the responsibility of Dr. Donald Hollsten, Dr. Jordan Hollsten, or their staff.
- ➔ I am giving the most accurate and current information to the best of my knowledge.

**SIGNATURE** _____ **DATE** _____

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## INSURANCE INFORMATION

**PRIMARY**
**(Please fill out with information of Primary Guarantor)**

**Last Name** _____ **First Name** _____ **MI** _____

**(circle one)** Dr. Mr. Mrs. Ms Other **(circle one)** Jr. Sr. Other **Nickname** _____

**Street Address** _____ **Suite/Apt.** _____

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

**Email** _____ **Phone** _____

**Date of Birth** _____ **SSN** _____

**Primary Insurance** _____

**Subscriber Number** _____ **Group Number** _____

**Claims Address (on back of card):** **Street** _____

**City/State/Zip** _____

**SECONDARY**
**(Please fill out with information of Secondary Guarantor)**

**Last Name** _____ **First Name** _____ **MI** _____

**(circle one)** Dr. Mr. Mrs. Ms Other **(circle one)** Jr. Sr. Other **Nickname** _____

**Street Address** _____ **Suite/Apt.** _____

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

**Email** _____ **Phone** _____

**Date of Birth** _____ **SSN** _____

**Secondary Insurance** _____

**Subscriber Number** _____ **Group Number** _____

**Claims Address (on back of card):** **Street** _____

**City/State/Zip** _____

* If applicable, please provide any TERTIARY INSURANCE on the back of this page

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**PATIENT MEDICAL HISTORY** *(check all that apply)*

**Ear/Nose/Throat**

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

**Heart Issues**

- ○ Chest Pain
- ○ Irregular Heart Beat
- ○ 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
- ○ _____

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**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 _____

## ALLERGIES

| | | | |
|---|---|---|---|
| Food | Yes | No | List: _____ |
| Medicine | Yes | No | List: _____ |
| Environmental | Yes | No | List: _____ |

**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 _____

**MEDICATIONS** **Please Provide Front Desk with a Full List of Medications or Write List on Back of This Page**

***SIGNATURE** _____ ***DATE** _____