



**EYE & FACIAL
PLASTIC SPECIALISTS**

Dr. Donald Hollsten & Dr. Jordan Hollsten

New Patient Information

PATIENT INFORMATION

Last Name _____ First Name _____ MI _____

(circle one) Jr. Sr. Other (circle one) M F Nickname _____

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 the visual field 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
- _____

