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** _____

EYE & FACIAL
PLASTIC SPECIALISTS
Dr. Donald Hollsten & Dr. Jordan Hollsten

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
- ❏ _____

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_____

*List additional Procedures on the back of this page

ALLERGIES

Food	Yes	No	_____
Medicine	Yes	No	_____
Environmental	Yes	No	_____

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 _____

SIGNATURE _____**DATE** _____