



**EYE & FACIAL  
PLASTIC SPECIALISTS**

Dr. Donald Hollsten & Dr. Jordan Hollsten

## New Patient Information for Minor Patients

### PATIENT INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 (circle one) Jr. Sr. Other (circle one) M F Nickname \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ Suite/Apt. \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email \_\_\_\_\_ Preferred Language \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Emergency Phone \_\_\_\_\_  
 Relationship to Patient \_\_\_\_\_

### RESPONSIBLE PARTY INFORMATION (if patient is a minor)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 (circle one) Jr. Sr. Other (circle one) M F Nickname \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ Suite/Apt. \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell 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 \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ Suite/Apt. \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 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 \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ Suite/Apt. \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_



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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.
- 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.
- 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

Referring Physician \_\_\_\_\_ OR Other Referral \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Cardiologist \_\_\_\_\_

## 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)*

<input type="checkbox"/> Diabetes	Family Member _____
<input type="checkbox"/> High Blood Pressure	Family Member _____
<input type="checkbox"/> Cancer	Family Member _____
<input type="checkbox"/> Stroke	Family Member _____
<input type="checkbox"/> Bleeding Disorder	Family Member _____
<input type="checkbox"/> Asthma	Family Member _____
<input type="checkbox"/> Immune System Disorder	Family Member _____
<input type="checkbox"/> Other _____	Family Member _____

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_