EDY N. HOLLENBERG, O.D.

Therapeutic Optometrist
Children & Adult Vision Care

"See the Difference"

Welcome To Our Office

Patient Information

Thank you for choosing our practice for your eye care needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name _____ Today's Date ___/___/___
First MI Last

Address _____ City _____ Zip_____

Birth date ___/___/___ Home phone# _____ Work phone#_____

Do you prefer to receive calls at ❑ Home ❑ Work ❑ Either

If you are a student, name of school/college _____ City_____ Zip _____

✈Whom may we thank for referring you to us? _____

Person to contact in case of emergency _____ Phone # _____

Responsible Party

Name of person responsible for this account _____

Birth date ___/___/___ Social Security # _____-____- _____ e-mail_____

Relationship to patient _____ Phone # _____ Mobile # _____

Address _____ City _____ Zip _____

Name of employer _____ Work # _____

Eye Health & Medical History

Date of last eye exam ___/___/___ Name of eye doctor _____

What is the reason for this appointment? _____

Have you had any injuries to your eyes? ❑ Yes What type?_____ ❑ No

Have you had any eye surgery? ❑ Yes What type? _____ ❑ No

Do you wear glasses? ❑ No ❑ All the time ❑ Reading/Near
❑ TV/Driving ❑ Computer ❑ Sunglasses

Do you wear contact lenses? ❑ Yes What type? _____ ❑ No

If no, are interested in contact lenses? ❑ Yes ❑ No

Are you interested in CRT? ❑ Yes ❑ No

Do you use a computer? ❑ Yes How many hours per day? _____ ❑ No

What hobbies or sports do you participate in? _____

✈ ***It is our mission to provide comprehensive eye care of the highest quality to you, your family, and our community. We promise to thoroughly explain your eye health status and vision needs with emphasis on preventive care, resulting in an enhanced quality of life. Our friendly staff is dedicated to providing this care in an atmosphere of compassion and respect. Our goal is to remain on the forefront of eye care through continuing education utilizing the latest state-of-the-art instrumentation, technology, contact lens and eyewear products. We will strive to exceed your expectations at a level of service and value, without reservation, to ensure you will return and recommend our office to others.***

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Do you have any of the following:

Blurred distance vision ?	❑ Yes	❑ No
Blurred near/reading vision ?	❑ Yes	❑ No
Burning eyes?	❑ Yes	❑ No
Itchy eyes?	❑ Yes	❑ No
Watery eyes?	❑ Yes	❑ No
Frequent headaches ?	❑ Yes	❑ No
Recent spots in your vision?	❑ Yes	❑ No
Flashes of light in your vision?	❑ Yes	❑ No
Double vision?	❑ Yes	❑ No

Do you or any blood relative have:

Diabetes	❑ Yes	Who? _____	❑ No
High blood pressure	❑ Yes	Who? _____	❑ No
Heart condition	❑ Yes	Who? _____	❑ No
Glaucoma	❑ Yes	Who? _____	❑ No
Cataracts	❑ Yes	Who? _____	❑ No
Blindness	❑ Yes	Who? _____	❑ No
Lazy eye	❑ Yes	Who? _____	❑ No
Thyroid	❑ Yes	Who? _____	❑ No
HIV	❑ Yes	Who? _____	❑ No
Cancer	❑ Yes	Who? _____	❑ No

Other significant health conditions I should be aware of: _____

List **all** medications you are currently taking including eye drops, vitamins & birth control pills

_____ _____
_____ _____
_____ _____
_____ _____

List your allergies to medications

_____
_____
_____
_____

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

SIGNATURE OF PATIENT (Or parent if a minor) DATE