Welcome To Our Office

Dr. Jeffrey K. Hollingsworth, O.D.

Personal Information

Patient Name: (Last, First M.I.)		**Birth Date:**	**Age:**	**Sex:** ❑Male ❑Female
Address:	**Apt. #**	**City:**	**St:**	**Zip Code:**
Occupation:	**Email:**	**HM Phone: ( )**		
Name of Parent (minors only)	**Marital Status:** ❑Single ❑Married ❑Widowed ❑Divorced	**WK Phone: ( )**		

Medical & Visual History

What is the primary reason for today's visit? (check all that apply) ❑Annual (Glasses) Exam ❑Contact Lens Exam ❑Infection / Other

When was your last Eye Exam?	**Who was your Eye Dr.?**

List Current Medications:

Have you or anyone in your family ever had any of the following? (Please Check all that apply)

History	You	Family	History	You	Family
Eye Surgery or Injury	❑	❑	High Blood Pressure	❑	❑
Diabetes	❑	❑	Multiple Sclerosis	❑	❑
Glaucoma	❑	❑	Thyroid Disease	❑	
Glasses	❑		Current Pregnancy	❑	
Contacts	❑		Lupus	❑	
Smoke (Current)	❑		Drug Reactions (Please Name)		

Hobbies or Activities:_____

❑Computer use:_____hrs./day

Other Concerns: _____

How did you find out about our office?

❑Whom may we thank for referring you to us?:

❑I've been here before ❑Location ❑Internet ❑Vision Center Staff ❑Insurance Company

Please list any family members who are current patients of Dr. Hollingsworth:

Financial and Office Policies

I, the patient or guardian, understand that all payments are due at the time that services are rendered. I am responsible for all outstanding balances. If I am using insurance, I am responsible for understanding my benefits and for providing full payment in the event my insurance company does not remit full payment, under any circumstance, within 60 days. All insurances must be authorized before the exam. All delinquent accounts will be sent to a collection agency for recovery and I am responsible for all fees. We, at Hollingsworth Family Eye Care, recognize that patients may need to cancel or change an appointment but request that they provide at least 24 hours notice. A $25 no show fee will apply to all future missed exams if 24 hours notice is not given.

Please select a desired form of payment: Cash Check MasterCard Visa Discover

I have read, understand and agree to the above Financial Policy.

Patient (or Guardian) Signature _____ **Date** _____

If paying with Check please present your Driver's License to the front desk.

We thank you for selecting Hollingsworth Family Eye Care to service your eye care needs.