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Advanced Eye Care of Grand Rapids
Welcome To Our Office

Welcome to Advanced Eye Care of Grand Rapids. Thank you for choosing us for your eye care needs. We are delighted to have you as a patient and appreciate the confidence you placed in us. Please take a moment to complete the following information. Any information we already have on file will appear on this form. Please review all areas to ensure the information we have is current and accurate. If you have any questions, please do not hesitate to ask.

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Male. ☐ Female

First Name | MI | Last Name

Street Address | City | State | Zip

Social Security Number | Date of Birth | Home Phone - Include Area Code | Work Phone

Email Address | Spouse or Parent(s) Name | Person Responsible For Account

Emergency Contact | Emergency Phone

How were you referred to our office?

☐ Phone Book ☐ School ☐ Advertisement ☐ Patient (Please Name)
☐ Insurance List ☐ Drive By ☐ Other ☐ Doctor (Please Name)

MAJOR MEDICAL INSURANCE INFORMATION

Name of Primary Medical Insurance | Address | City | State | Zip

☐ M ☐ F Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship To Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Patient Status

☐ Single ☐ Married ☐ Other
☐ Full Time Student ☐ Part Time Student ☐ Employed

VISION PLAN INFORMATION

Name of Vision Plan Company | Address | City | State | Zip

☐ M ☐ F Insured's First Name | MI | Insured's Last Name

Insured's Identification Number | Group Number | Insured's Date of Birth

Patient Relationship To Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

PLEASE READ:

Examination fee is due at the time of service. All contact lenses must be paid in full before ordering. Any co-payments are due at the time of service. If you have insurance coverage you will use for these services or materials, we will submit claims for you. However, we are not liable for collecting your claim. After 30 days, we will expect payment in full if your insurance company has not paid. Returned checks will be charged a service fee of $50.00.
I HEREBY AUTHORIZE MY INSURANCE CARRIER TO MAKE PAYMENT DIRECTLY TO ADVANCED EYE CARE OF GRAND RAPIDS FOR ANY AND ALL SERVICES RENDERED TO ME BY ADVANCED EYE CARE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE. I also release any information regarding my treatment or condition in order to obtain payment for professional services. I acknowledge that I have read Dr. Holser's NOTICE OF PRIVACY PRACTICES.

Signature | Date

PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician Name | Clinic Name

Address of Primary Care Physician | City | State | Zip | Phone

REFERRING PHYSICIAN

Referring Physician Name | Clinic Name

Address of Referring Physician | City | State | Zip | Phone

HEALTH HISTORY

What is the main reason for today's exam?

When was your last eye exam?

When was your last health exam?

Past Illnesses or Injuries:

Past Surgeries:

Current Medications

Current Eye Drops:

Medicines that cause reactions or sensitivitie:s

Specific Allergies:

EYE HISTORY

Glaucoma	☐ Yes	☐ No	Dryness	☐ Yes	☐ No				
Cataract	☐ Yes	☐ No	Excess Tearing/Watering	☐ Yes	☐ No	Strabismus (Crossed Eyes)	☐ Yes	☐ No	
Macular Degeneration	☐ Yes	☐ No	Eye Pain or Soreness	☐ Yes	☐ No	Blurred Vision at Distance	☐ Yes	☐ No	
Retinal Detachment	☐ Yes	☐ No	Foreign Body Sensation	☐ Yes	☐ No	Blurred Vision at Near	☐ Yes	☐ No	
Color Blindness	☐ Yes	☐ No	Infection of Eye or Lid	☐ Yes	☐ No	Distorted Vision (Halos)	☐ Yes	☐ No	
Headaches	☐ Yes	☐ No	Itching	☐ Yes	☐ No	Double Vision	☐ Yes	☐ No	
Glare/Light Sensitivity	☐ Yes	☐ No	Mucous Discharge	☐ Yes	☐ No	Floaters or Spots	☐ Yes	☐ No	
Tired Eyes	☐ Yes	☐ No	Drooping Eyelid	☐ Yes	☐ No	Fluctuating Vision	☐ Yes	☐ No	
Amblyopia (Lazy Eye)	☐ Yes	☐ No	Redness	☐ Yes	☐ No	Loss of Vision	☐ Yes	☐ No	
Burning	☐ Yes	☐ No	Sandy or Gritty Feeling	☐ Yes	☐ No	Loss of Side Vision	☐ Yes	☐ No	

GENERAL HEALTH CONDITION

Fever	☐ Yes	☐ No	Respiratory (Asthma)	☐ Yes	☐ No	Anxiety or Depression	☐ Yes	☐ No	
Weight Loss	☐ Yes	☐ No	Gastrointestinal	☐ Yes	☐ No	Endocrine (Thyroid, Diabetes)	☐ Yes	☐ No	
Other Symptoms	☐ Yes	☐ No	Kidney	☐ Yes	☐ No	Blood.Lymph	☐ Yes	☐ No	
Ear, Nose, Throat	☐ Yes	☐ No	Muscles, Bones, Joints	☐ Yes	☐ No	Allergic	☐ Yes	☐ No	
Cardiovascular (High Blood Pressure, etc.)	☐ Yes	☐ No	Neurological (MS)	☐ Yes	☐ No	Pregnant	☐ Yes	☐ No	
						Nursing	☐ Yes	☐ No	

FAMILY HISTORY

Amblyopia(Lazy Eye)	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No	Macular Degeneration	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Blindness	☐ Yes	☐ No	Strabismus (Eye Turn)	☐ Yes	☐ No	Strabismus (Eye Turn)	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Color Blindness	☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Others	☐ Yes	☐ No

SOCIAL HISTORY

Current Occupation: Years Employer

Do you use a computer? ☐ Yes ☐ No How many hours each/day? Distance from computer?

Do you drive? ☐ Yes ☐ No Mileage to work each way? Do you have glare problems? ☐ Yes ☐ No

Do you have visual difficulty when driving? ☐ Yes ☐ No Do you have problems with night vision? ☐ Yes ☐ No

Do you currently wear glasses? ☐ Yes ☐ No Since

Type of Glasses ☐ Full Time ☐ Part Time ☐ Distance ☐ Close

Glasses Owned ☐ Single Vision ☐ Bifocals ☐ Trifocals ☐ Backup ☐ Safety ☐ Sports ☐ Progressive

Do you plan on updating your glasses today? ☐ Yes ☐ No

Have you had trouble in the past with glasses? ☐ Yes ☐ No Please Explain

Do you wear sunglasses? ☐ Yes ☐ No Are your sunglasses your current prescription? ☐ Yes ☐ No

SPECIEAL EYEWEAR NEEDS

☐ Computer (special prescriptions, special antiglare, tints or coatings ☐ Safety Glasses (gardening, woodworking, welding)

☐ Occupational (mechanics, plumbers, pilots) ☐ Sports/Hobbies (raquet sports, motorcycle)

CONTACT LENS HISTORY

Are you interested in the latest technology in ccontact lenses? ☐ Yes ☐ No

Do you currently wear contac lenses? ☐ Yes ☐ No Since

If not a contact lens wearer, are you interested in trying trying contact lenses at this time? ☐ Yes ☐ No

Type and brand of contact lenses Today's wearing time

How many hours/day? How many days/week?

Please rate the following on a scale of 1-10, with 1 being POOR to 10 being EXCELLENT

	Right	Left		Right	Left		Right	Left
Current Lens Comfort			Distance VIsion			Near VIsion		

What solutions do you use? Cleaner Disinfectant Enzyme

SOCIAL HISTORY

Do you use nutritional supplements (vitamins, etc.)? ☐ Yes ☐ No

Do you engage in regular exercise? ☐ Yes ☐ No

Do you drink alcohol? If yes, how much/often? ☐ No ☐ Occasional ☐ 1 per day ☐ 2 per day ☐ 2-3/day ☐ 4+/day

Do you drink smoke? If yes, how much/often? ☐ No ☐ Occasional ☐ 1/2 pack/day ☐ 1 pack/day ☐ 1+pack/day

Method of tobacco intake ☐ Smoking ☐ Chewing

Do you use illegal drugs? ☐ Yes ☐ No

Hobbies and Interests

Are you interested in laser vision correction surgery? ☐ Yes ☐ No

Would you be interested in a non-surgical method to correct vision? ☐ Yes ☐ No

Submit by Email Print Form