



HOLLAND MEDICAL EYE CENTER

2171 Junipero Serra Blvd. Suite 100
Daly City, CA 94014

Patient ID No: _____

PATIENT HISTORY FORM

DATE OF BIRTH _____ LAST NAME _____ FIRST NAME _____

ADDRESS _____

CITY _____ ZIP _____ EMAIL _____

Marital Status _____ Employment Status/Occupation _____ Employer _____

PHONE NUMBERS:

HOME _____ CELL _____ WORK _____

HEALTH INFORMATION

Reason for Visit: routine, new glasses, contacts, blurred vision, red eye, cataracts, glaucoma, botox

Other: _____

Primary Care Doctor: _____

Allergies to Medications: _____

Medications Currently Taking: _____

Types of Insurance: Major Health Insurance: _____ Vision Insurance: _____
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INSURANCE SIGNATURE ON FILE

I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to Holland Medical Eye Center on my behalf for any services and material furnished. I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer or agency shown, and authorizes my doctor to act as my agent, as above. HIPPA form reviewed. If I am being referred to this facility, I acknowledge that it may be from a health care facility in which the referring practitioner has financial interest. I understand that I may patronize any physician of my choosing.

Lifetime Patient Signature: _____

Date: _____

VSP Patients

I understand that my medical records are confidential. I understand that by signing this form I am allowing my medical information to be released upon VSP's request to VSP for the purpose of Health Care Operations(including but not limited to, provider review functions, claims payment and quality assessment). I also understand that I may revoke this consent by written request at any time, with this doctor. If revoked, it is understood by all parties that all information released prior to being notified of such revocation was made with my consent. For additional information on VSP's Patient Confidentiality Policy, please refer to: www.vsp.com. VSP updates the Patient Confidentiality Policy periodically and reserves the rights to make changes as required. I understand that I have the right to restrict the disclosure of specific information in my medical records if I request such restriction may be denied if the information restricted is required for Health care Operations. HIPPA form reviewed.

I have read the above and foregoing consent for release of information and acknowledge that I am familiar with and fully understand the terms and condition of the consent.

Signature: _____

Date: _____