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**__________________

HOME#__________________________**CELL#**____________________________**WORK#**___________________________

HEALTH INFORMATION

Reason for Visit: __routine, __new glasses, __contacts, __blurred vision, __red eye, __cataracts, __glaucoma,

Other: ________________________________

Health Conditions: __Diabetes __Hypertension __High Cholesterol

__Diabetic Retinopathy __None

Primary Care Doctor: __________________________________

Allergies to Medications: _______________________________

Medications Currently Taking: ____

Types of Insurance:

Major Health Insurance:_____________

Vision Insurance: __________________

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 medic al 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: _________________________