EYECARE Professionals
Dr. Mollie Golden · 308.221.2020

Last Name: _____ Legal First Name: _____ Nickname: _____ M: _____ DOB: _____
M or F SSN: _____ Marital Status: Married/Single/Divorced/Widowed
Address: _____ City: _____ State: _____ Zip: _____
Home Ph.: (_____) _____ Work Ph.: (_____) _____ Cell Ph.: (_____) _____
Email Address: _____ Sports/Hobbies: _____
Preferred Method of Contact: ☐ Email ☐ Texting preferred YES/NO ☐ Cell Phone ☐ Home Phone ☐ Work Phone
Employer/School: _____ Occupation/School Grade: _____
Emergency Contact: _____ Relation: _____ Phone #: _____
How did you hear about our office? _____

Height: _____Ft. _____in. Weight:_____ Pharmacy:_____
Date of Last Medical Exam: _____ Primary Physician/Clinic: _____
Date of Last Eye Exam:_____ Eye Doctor:_____

Medical History	**No**	**Yes**
Cancer	☐	☐
Sinus/Congestion	☐	☐
Stroke	☐	☐
Heart Disease	☐	☐
High Cholesterol	☐	☐
High Blood Pressure	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Kidney Problems	☐	☐
Arthritis	☐	☐
Crohn's Disease	☐	☐
Rosacea	☐	☐
Eczema	☐	☐
Multiple Sclerosis	☐	☐
Migraines	☐	☐
Seizures	☐	☐
ADHD	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Thyroid Disease (Hyper/Hypo)	☐	☐
Anemia	☐	☐
Diabetes	☐	☐

Blood Sugar_____Taken_____
A1C_____Taken_____

Family History	**None**	**Mother**	**Father**	**Grandparent**	**Unknown**
Diabetes	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐	☐
Macular Degen	☐	☐	☐	☐	☐
Retinal Detach	☐	☐	☐	☐	☐
Crossed/ Lazy Eyes	☐	☐	☐	☐	☐

	No	**Yes**	
Tetanus shot in the last ten years?	☐	☐	
Are you currently pregnant or nursing?	☐	☐	
Alcohol Use?	☐	☐	Amount?_____
Tobacco Use?	☐	☐	Amount?_____

Medications:_____
_____
_____

Allergies (to medication and/or seasonal):_____
_____
_____

Surgeries in the last two years:_____
_____

Insurance Authorization/HIPAA Notice

☐ I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.
☐ I acknowledge that I had the opportunity to review and have received a copy if so desired of Eye Care Professionals' Notice of Privacy Practices.

Signature: _____ **Date:** _____