☐ New patient
☐ Update

BENEFIELD EYE CARE, PC

PATIENT INFORMATION

We are delighted to see you.

ALL INFORMATION IS STRICTLY CONFIDENTIAL

Your insurance company requires the following information.

TODAY'S DATE ______________________ REFERRED BY ______________________

PATIENT'S NAME ______________________ BIRTHDATE ______________ AGE ________

SOCIAL SECURITY # ______________________ MARITAL STATUS ______________ M F ________

STREET ADDRESS ____

City ▲ State ▲ Zip Code ▲

HOME ( ) ____-____ WORK ( ) ____-____ CELL ( ) ____-____ E-MAIL ______________________

EMPLOYER ______________________ ADDRESS ______________________ ZIP ________

EMERGENCY CONTACT ______________________ PHONE ( ) ____-____

NAME OF PARENT / GUARDIAN IF A MINOR ______________________

SSN # OF PARENT / GUARDIAN OF MINOR ______________ DOB OF MINOR'S PARENT / GUARDIAN ______________

EMPLOYER OF PARENT / GUARDIAN ______________________

PARENT / GUARDIAN WORK PHONE ______________ CAN WE CALL YOU AT WORK? ☐ YES ☐ NO

• •

PRIMARY INSURANCE COMPANY ______________________ POLICY # ______________

INSURED NAME ______________________ SSN # ______________

IS INSURANCE THROUGH EMPLOYER? ☐ YES ☐ NO GROUP # ______________

ANY SECONDARY INSURANCE? ______________________

WHO IS RESPONSIBLE FOR THIS BILL? ______________________

ADDRESS OF RESPONSIBLE PARTY ____

City ▲ State ▲ Zip Code ▲

★★★★★ ***PLEASE WRITE ANY ADDITIONAL INFORMATION ON THE BACK OF THIS FORM*** ★★★★★

I understand that I am financially responsible for all charges and services. This includes the balance remaining after payment of possible insurance benefits. I authorize payment of medical benefits to myself or the names provided above for professional services rendered. I authorize the release of any medical information necessary to process my claims only.

SIGNED ______________________ DATE ______________
Signature of patient (If a minor, parent or guardian's signature is required)

I understand that my pupils may be dilated, which could temporarily cause glare and near vision difficulty.

SIGNED ______________________ DATE ______________
Signature of patient (If a minor, parent or guardian's signature is required)

Refraction (glasses examination) is a measurement of the patient's preference for the focusing of the eyes, which may be used to purchase glasses and/or contact lenses. This measurement gives the doctor your best vision, which is an important component of a thorough eye exam. A refraction is not included in the approval fee for an Eye Examination and therefore is billed separately to the patient. I understand that if this service is provided I am responsible for the fee, which currently is $30.00.

SIGNED ______________________ DATE ______________
Signature of patient (If a minor, parent or guardian's signature is required)

BENEFIELD EYE CARE, P.C.
COMPREHENSIVE HISTORY QUESTIONNAIRE

Your insurance company requires the following information.

(MALE / FEMALE)

Name ______________________________ Today's Date ______________

Patient's date of birth ______________________________
Month / Day / Year

CURRENT MEDICAL PROBLEMS

Please list your current medical conditions (e.g. diabetes, high blood pressure, arthritis, etc.) ______________

____

____

Have you ever had any eye disease (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)?
No ❑ Yes ❑ IF YES, please explain: ______________________________

____

Have you ever had any surgery/hospitalization? No ❑ Yes ❑ IF YES, please provide date and reason.

____

CURRENT MEDICATIONS

Please list all medications you are now taking, including those you buy without a doctor's prescription (such as aspirin, cold tablets or vitamin supplements). List name, dosage, and times per day.

1.______________ 3.______________ 5.______________
2.______________ 4.______________ 6.______________

CURRENT ALLERGIES, SENSITIVITIES AND INTOLERANCES

List anything that you are allergic to, such as certain foods, medications, dust, chemicals, etc., and indicate how each affects you: ______________________________

____

____

OTHER MEDICAL CARE

If you are being treated for any other illnesses or medical problems by another physician or physical or mental health practitioner, please describe the problems, write the name of the physician, health practitioner or medical facility treating you. Use back of the page if needed. Check if additional information is listed on back. ❑

ILLNESS OR MEDICAL PROBLEM

____

____

____

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)? No ❑ Yes ❑ IF YES, please explain. ______________________________

____

Do you or have you ever smoked? No ❑ Yes ❑ IF YES, how much?______ When did you quit? __________
Drink alcohol? No ❑ Yes ❑ IF YES, how much? __________

PLEASE COMPLETE BACK OF FORM

REVIEW OF SYMPTOMS: Do you currently have any of the following problems?

	Yes	No
Chronic fever, unexpected weight loss/gain, fatigue	❑	❑
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	❑	❑
Heart problems (e.g. chest pains, irregular heart beat)	❑	❑
Respiratory problems (e.g. shortness of breath, wheezing, coughing)	❑	❑
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	❑	❑
Urinary problems (e.g. pain or discomfort, blood in urine)	❑	❑
Skin problems (e.g. rashes, excessive dryness)	❑	❑
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)	❑	❑
Neurological problems (e.g. numbness, weakness, headaches, paralysis)	❑	❑

Additional patient health information: ______________________________

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Comments: *(Office use only)* ______________________________

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______________________________ Physician's Signature

______________________________ Date