BENNETT EYE INSTITUTE

Patient Information

Last Name: ______________________ First Name: ______________________ MI: ________

DOB: ______________________ SS#: ______________________

❑ Male ❑ Female

❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Address: ____

City: ______________________ State: __________ Zip: ______________

Home Phone: ______________________ Mobile Phone: ______________________

Email: ______________________ Occupation: ______________________

Employer: ______________________ Work Phone: ______________

Preferred Method of Contact: ❑ Home ❑ Work ❑ Mobile ❑ Email

Emergency Contact: ____

Relationship: ______________________ Phone: ______________________

Primary Insurance: ______________________ Subscriber: ______________

Subscriber #: ______________________ Relationship: ______________ DOB: __________

Medical Coverage or Group: ______________ Employer: ______________________

Secondary Insurance: ______________________ Subscriber: ______________

Subscriber #: ______________________ Relationship: ______________ DOB: __________

Medical Coverage or Group: ______________ Employer: ______________________

Other Insurance: ______________________ Subscriber: ______________

Subscriber #: ______________________ Relationship: ______________ DOB: __________

Medical Coverage or Group: ______________ Employer: ______________________

Office Use Only

Date: __________ Int: ______ Date: __________ Int: ______ Date: __________ Int: ______

Date: __________ Int: ______ Date: __________ Int: ______ Date: __________ Int: ______

Date: __________ Int: ______ Date: __________ Int: ______ Date: __________ Int: ______

1620 Ala Moana Boulevard
Suite 500 | Honolulu, HI 96815
(808) 955-0255

98-1247 Kaahumanu Street
Suite 310 | Aiea, HI 96701
(808) 955-0255

94-216 Farrington Highway
Suite B2-203 | Waipahu, HI 96797
(808) 671-4778

Preferred Pharmacy: ____________________

Who referred you to us? ____________________

Please list all of your medical providers:

Name: ____________ Specialty: ____________ Phone: ____________

Name: ____________ Specialty: ____________ Phone: ____________

Name: ____________ Specialty: ____________ Phone: ____________

Do you smoke? ❍ Yes ❍ No How much/often? ____________

Do you drink alcohol? ❍ Yes ❍ No How much/often? ____________

Do you exercise? ❍ Yes ❍ No How much/often? ____________

Do you have any allergies to medications? ❍ Yes ❍ No What medications? ____________

Do you have any allergies to iodine/shellfish? ❍ Yes ❍ No

Do you have any allergies to to latex? ❍ Yes ❍ No

Do you have any other allergies? ❍ Yes ❍ No

EYE HISTORY

Do you have a history of:

Diabetic Retinopathy ❍ Yes ❍ No Treatment: ____________

Macular Degeneration ❍ Yes ❍ No Treatment: ____________

Retinal Detachment ❍ Yes ❍ No Treatment: ____________

Glaucoma ❍ Yes ❍ No Treatment: ____________

Cataracts ❍ Yes ❍ No Treatment: ____________

Laser Surgery ❍ Yes ❍ No Treatment: ____________

Other: ____________ ❍ Yes ❍ No Treatment: ____________

SURGICAL HISTORY

List all surgeries, treatments, procedures and implants you have had:

____________ Year: ____________

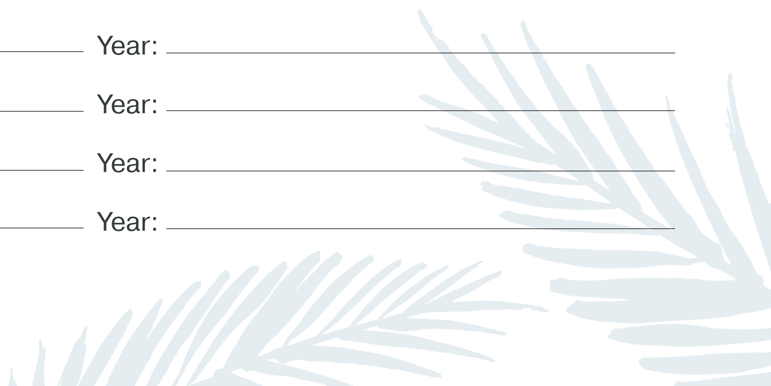
____________ Year: ____________

____________ Year: ____________

____________ Year: ____________

____________ Year: ____________

____________ Year: ____________



MEDICAL HISTORY

Please check yes and provide the date of diagnosis for any medical problems you presently have or have had in the past, otherwise, check no.

General			Year Diagnosed
Weight loss	❍ Yes	❍ No	______
Lack of energy	❍ Yes	❍ No	______
Trouble sleeping	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Eyes			
Vision loss	❍ Yes	❍ No	______
Changes in vision	❍ Yes	❍ No	______
Eye pain	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Ears, Nose, Mouth & Throat			
Hearing loss	❍ Yes	❍ No	______
Sinus problems	❍ Yes	❍ No	______
Infections	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Cardiovascular			
Heart attack	❍ Yes	❍ No	______
High blood pressure	❍ Yes	❍ No	______
Heart murmur	❍ Yes	❍ No	______
Irregular heart beat	❍ Yes	❍ No	______
Mitral valve prolapse	❍ Yes	❍ No	______
Chest pain	❍ Yes	❍ No	______
Circulation problems	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Respiratory			
Asthma	❍ Yes	❍ No	______
Bronchitis	❍ Yes	❍ No	______
Shortness of breath	❍ Yes	❍ No	______
Emphysema	❍ Yes	❍ No	______
Tuberculosis	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Gastrointestinal			
Ulcers	❍ Yes	❍ No	______
Diverticulitis	❍ Yes	❍ No	______
Constipation	❍ Yes	❍ No	______
Hepatitis	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Genitourinary			Year Diagnosed
Kidney infections	❍ Yes	❍ No	______
Urinary infections	❍ Yes	❍ No	______
Cancer	❍ Yes	❍ No	______
Prostate	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Bones, Joints & Muscle			
Osteoporosis	❍ Yes	❍ No	______
Arthritis	❍ Yes	❍ No	______
Muscle pain	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Integumentary			
Keloid/scarring	❍ Yes	❍ No	______
Skin rash/sensitivity	❍ Yes	❍ No	______
Skin cancer	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Nervous System			
Seizure	❍ Yes	❍ No	______
Stroke	❍ Yes	❍ No	______
Paralysis/weakness	❍ Yes	❍ No	______
Numbness	❍ Yes	❍ No	______
Migraines	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Endocrine System			
Diabetes	❍ Yes	❍ No	______
Kidney dialysis	❍ Yes	❍ No	______
Thyroid	❍ Yes	❍ No	______
High cholesterol	❍ Yes	❍ No	______

Blood			
Anemia	❍ Yes	❍ No	______
Excessive bleeding	❍ Yes	❍ No	______
Bruising	❍ Yes	❍ No	______
Clotting problems	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

Immunologic			
Lupus	❍ Yes	❍ No	______
Rheumatoid arthritis	❍ Yes	❍ No	______
HIV	❍ Yes	❍ No	______
Other	❍ Yes	❍ No	______

MEDICATIONS

Please list all medications you are currently taking, including non-prescription medications and vitamins:

Medication	Dose	How often	Reason for use

FAMILY MEDICAL HISTORY

Have any members of your family (parents, siblings, grandparents) had any of the following medical problems:

If yes, please indicate who has the condition

Diabetes	❍ Yes	❍ No	________	Tuberculosis	❍ Yes	❍ No	________
Thyroid disease	❍ Yes	❍ No	________	Heart disease	❍ Yes	❍ No	________
Stroke	❍ Yes	❍ No	________	High blood pressure	❍ Yes	❍ No	________
Anemia	❍ Yes	❍ No	________	Kidney disease	❍ Yes	❍ No	________
Hepatitis	❍ Yes	❍ No	________	Bleeding disease	❍ Yes	❍ No	________
Cancer	❍ Yes	❍ No	________	Other	❍ Yes	❍ No	________

Have any members of your family (parents, siblings, grandparents) had any of the following eye problems:

Retinal detachment	❍ Yes	❍ No	________	Glaucoma	❍ Yes	❍ No	________
Diabetic retinopathy	❍ Yes	❍ No	________	Cataract	❍ Yes	❍ No	________
Macular degeneration	❍ Yes	❍ No	________	Other	❍ Yes	❍ No	________

Your eyes will be dilated for your eye exam. Dilation will make the pupils of your eyes large for several hours and can cause light sensitivity, glare and blurred vision, especially up close. Dark glasses are recommended. If you do not have your own please ask us for a pair.

____ ________________

Patient or Representative Signature Date

BENNETT
EYE INSTITUTE

Billing Procedures

We will be unable to bill your insurance unless we have a current insurance card or a completed insurance form for each insurance carrier. We will make every effort, on your behalf, to collect payment from your insurance company first. You are responsible for any co-payment at the time of service. To keep your costs as low as possible, we ask that you assist us with our billing procedures.

Medicare Patients: Our physicians are Medicare participating providers. This means that we will bill Medicare the Medicare allowed fee with the remaining 20% payable by you or your Medicare supplement insurance. Medicare patients are also responsible for the annual Medicare deductible and all non-covered services. All patient portions are payable at the time of service.

Participating Insurance Plans: All charges will be billed. All patient portions and non-covered services will be collected on the day of your visit.

Managed Care Plans (HMO): Our doctors are participating providers with many Managed Care Insurance Plans. If you are a member of one of these plans, we will ask you for a referral form from your primary care physician. You will be responsible for any co-payment and non-covered services, which are payable at the time of service. The balance will be billed directly to your insurance company.

Medicaid: You must have your current Medicaid card. All charges will be billed. All patient portions and non-covered services will be collected on the day of your visit.

Non-Participating Insurance: If you have insurance with a private carrier, we will make every effort to bill your insurance company first. You will be responsible for all charges incurred, payable at the time of your visit. Your private insurance company will reimburse you directly. Any such request must be accompanied by a completed insurance form at each visit, unless your insurance carrier accepts the standard HCFA 1500 form.

Non-Covered Services and Taxes: There are some services, as well as taxes, that your medical insurance may not cover at all and payment for these services and taxes are your responsibility. Payment for these non-covered services and taxes are collected at the time of your visit.

Payments, deductibles, other: All payments that are your responsibility are due at the time services are rendered. Cash, VISA, MasterCard, Discover, AMEX or personal check from a local bank is accepted. There will be a $20 service charge for all returned checks. In the event your account becomes delinquent, you are responsible for all additional charges incurred.

While filing of insurance claims is a courtesy that we extend to our patients, some charges such as deductibles and co-payments are your responsibility. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we ask that you contact us promptly for assistance with the management of your account.

The care of your eyes and your vision are our primary concern. Should you have any questions concerning this policy, please feel free to contact us at (808) 955-0255.

Authorization: I certify that the information I have provided to Bennett Eye Institute is true and correct. I understand that I am responsible for all charges for services provided by the Bennett Eye Institute. I authorize release of any information from my files, including, but not limited to, my medical and financial records necessary to process my insurance claims and request payment of insurance benefits to either myself or the party who accepts assignment/participation with my insurance company.

Patient/Representative Signature Date

Medicare/Medigap Long-Term Authorization: I request that payment of authorized Medicare/Medigap benefits be made either to myself or on my behalf to Bennett Eye Institute for any services, current or future, provided to me by the Bennett Eye Institute. I authorize Bennett Eye Institute to release to the Health Care Financing Administration and its agents, information needed from my files including, but not limited to, my medical and financial records for determination of benefits and/or the benefits payable for related services.

Patient/Representative Signature Date

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