

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: _____

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 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

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 _____

Year Diagnosed

Genitourinary

Kidney infections Yes No _____
Urinary infections Yes No _____
Cancer Yes No _____
Prostate Yes No _____
Other Yes No _____

Year Diagnosed

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	<input type="radio"/> Yes <input type="radio"/> No _____	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No _____
Thyroid disease	<input type="radio"/> Yes <input type="radio"/> No _____	Heart disease	<input type="radio"/> Yes <input type="radio"/> No _____
Stroke	<input type="radio"/> Yes <input type="radio"/> No _____	High blood pressure	<input type="radio"/> Yes <input type="radio"/> No _____
Anemia	<input type="radio"/> Yes <input type="radio"/> No _____	Kidney disease	<input type="radio"/> Yes <input type="radio"/> No _____
Hepatitis	<input type="radio"/> Yes <input type="radio"/> No _____	Bleeding disease	<input type="radio"/> Yes <input type="radio"/> No _____
Cancer	<input type="radio"/> Yes <input type="radio"/> No _____	Other	<input type="radio"/> Yes <input type="radio"/> No _____

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

Retinal detachment	<input type="radio"/> Yes <input type="radio"/> No _____	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No _____
Diabetic retinopathy	<input type="radio"/> Yes <input type="radio"/> No _____	Cataract	<input type="radio"/> Yes <input type="radio"/> No _____
Macular degeneration	<input type="radio"/> Yes <input type="radio"/> No _____	Other	<input type="radio"/> Yes <input type="radio"/> 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



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