

Patient Information

New Patient

 Title Dr. Mr. Mrs. Ms. Sex M F

Patient

First name _____

Last name _____

D.O.B. _____

SS# _____

Address

Street address _____

ZIP Code _____

City _____

State _____

Phone/ Fax

Home Phone _____

Cell Phone _____

Work Phone _____

E-mail _____

Marital status/(check one) Single Married Divorced Separated Widowed

Occupation _____

Employer

Name _____

Phone _____

Spouse

Name _____

Employer _____

Person responsible for bill _____

D.O.B. _____

Address (if different) _____

Phone/ Fax _____

Is this person a patient here? Yes NoIs this patient covered by insurance? Yes No

Subscriber

Name _____

D.O.B. _____

SS# _____

Group no. _____

Policy no. _____

Co-payment (\$) _____

Patient's relationship to subscriber Self Spouse Child Other

Name of secondary insurance (if applicable)

Subscriber

Name _____

D.O.B. _____

SS# _____

Group no. _____

Policy no. _____

Co-payment (\$) _____

Patient's relationship to subscriber Self Spouse Child Other

In Case of Emergency

Name of local friend or relative (not living at same address) _____

Relationship to Patient _____

Phone

Home Phone _____

Work Phone _____

Date _____

Signature of patient or person acting on patient's behalf _____

Eye Health History

Physician _____
Name _____

_____ Date of last visit

Eye Doctor _____
Name _____

Do you wear glasses? No Yes: All the time, Occasionally, Reading, Driving, TV
(Circle as true)

Do you wear contacts? No Yes: Type _____ Hours/Day _____

Describe any problems you have with your contacts

Place a mark on **Yes** or **No** to indicate if you have had any of the following →

	Yes	No		Yes	No
Bloodshot Eye	<input type="checkbox"/>	<input type="checkbox"/>	Floaters or Spots	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision-Distance	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision-Near	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Burning Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Itching Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Light Sensitive	<input type="checkbox"/>	<input type="checkbox"/>
Color Vision, Poor	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Night Vision, Poor	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>	Red Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Seeing Halos	<input type="checkbox"/>	<input type="checkbox"/>
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Seeing Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	Twitching Eyelid	<input type="checkbox"/>	<input type="checkbox"/>
Eye Strain	<input type="checkbox"/>	<input type="checkbox"/>	Vision Poor	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells. Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Watering Eyes	<input type="checkbox"/>	<input type="checkbox"/>

Please tell us how you learned of our practice or whom we may thank. →

I was a Former Patient

Former Patient recommendation

_____ Name

Doctor recommendation

_____ Name

Family or Friend recommendation

_____ Name

Insurance Company recommendation

Employer recommendation

Newspaper advertisement

Yellow Page advertisement

Web page

_____ Name of the web page

TV advertisement

Radio advertisement

Internet Search Engine

_____ Name

I learned about you another way

_____ Please explain

Are you interested in LASIK?

General Health History

Place a mark on **Yes** or **No** to indicate if you have had any of the following. →

Also place a mark to indicate if a blood relative has had any of the following problems. →

Physician

Name _____

Phone _____

Date of last visit _____

	Yourself		Family Mem.			Yourself		Family Mem.	
	Yes	No	Yes	No		Yes	No	Yes	No
AIDS /HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (Type____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Turned Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you pregnant? Yes No

Number of Children _____

Alcohol use Yes No

Tobacco use Yes No

Medications

List medications you are currently taking, including eye drops →

Pharmacy

Name _____

Phone _____

Allergies

List your allergies to medications or other substances →

Submission of Insurance Claims

I hereby authorize the Benjamin Eye Institute, and Arthur Benjamin, MD, to furnish any and all information necessary for the processing of insurance claims. This may include providing information, including but not limited to findings, diagnoses, illnesses and accidents to the appropriate third party payers.

Initial

Insurance Payments

I hereby irrevocably assign to Dr. Arthur Benjamin all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Initial

Copays and Deductibles

I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

Initial

Surgical Center Interest

I am aware that Dr. Benjamin has a less than 1% partnership interest in the Specialty Surgical Center, where he performs cataract and other ocular surgery.

Initial

Bounced Checks

I understand that a \$50 fee will be charged for any returned checks.

Initial

Medical Records

I understand that BEI maintains a state of the art electronic health record . I understand that if ever I need a copy of my records a paper version can be generated. I understand that I will be responsible for the administrative and printing costs associated with production of such a paper record. The current fee for this is \$50, but may increase in the future without notice. I understand I will be charged such a fee every time I need a copy of my records transferred to me or to another healthcare provider or facility.

Initial

Forms

I understand that I am responsible for administrative costs involved with filling out forms such as DMV form (\$25), Social Security forms (\$75), Employee forms (\$50-\$100), Diagnosis Letters (\$100).

Initial

Refraction

Prescription for glasses

I understand that most insurance companies including Medicare don't consider refraction or contact lens fitting a medically necessary and coverable service. I understand that I will be responsible for a charge for refraction, currently \$50.

Initial

A copy of this authorization shall be considered as valid as the original.

Date

Signature of patient or guardian

Notice of Privacy Practices

The Notice of Privacy Practices tells you how we may use and share your health records. Please read it.

Acknowledgement

1. We will use and share your health records to treat you and to bill for the services we provide.
2. We will use and share your health records to run our business.
3. We will use and share your health records as required by law.

Your Rights

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your records (fee applies);
2. you have the right to receive a list of whom we have given your health records to;
3. you have the right to ask us to correct a mistake in your health records;
4. you have the right to ask that we not use or share your health records;
5. you have the right to ask us to change the way we contact you.

I have received or have been offered a copy of the above Notice of Privacy Practices.

Consent

I consent to the use and sharing of my health records for treatment, payment, and operation purposes. I know that if I do not consent, you cannot provide services to me.

Date

Signature of patient or legal representative

<p>NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.</p>
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OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)