Bennett Vision
EXCELLENCE IN EYE CARE SINCE 1990

Date:

Legal Name: (Nick name):

Address:

City: ST: Zip:

Email:

DOB: SSN #

CIRCLE ONE

Race: African American Alaskan Native American Indian
Asian Hispanic Latino
Pacific Islander White Other

Height:

Weight:

Spoken Language:

Written Language:

Allergies to medication:

Vision Insurance: **Medical Insurance:**

FAILURE TO NOTIFY OUR OFFICE MAY RESULT IN LOSS OF SOME OR ALL OF YOUR BENEFITS OF COVERAGE

Our office files insurance as a service to our patients, but we can not guarantee payment of benefits.

I, the undersigned certify that (or my dependent) have insurance coverage and assign insurance benefits, if any, directly to provider. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to insure the payment of benefits. I authorize the use of this signature on all insurance submissions. I agree to cover all charges for myself and my dependents that insurance does not cover. I also understand for any reason I am turned over to collections for nonpayment, I will owe an additional 30% collections fee of my entire bill.

Signature:

Date:

Bennett Vision

Confidential Medical History

EYE HEALTH
Any problems with:

Blurred (Distance)	Yes	No
Blurred (Near)	Yes	No
Night Blindness	Yes	No
Glare	Yes	No
Light Sensitivity	Yes	No
Dry Eye	Yes	No
Water Eyes	Yes	No
Itchy Eyes	Yes	No
Floaters	Yes	No
Eye Strain	Yes	No
Double Vision	Yes	No
Eye Pain	Yes	No
Do you wear Contact Lenses	Yes	No
Cataracts	Yes	No
Glaucoma	Yes	No
Macular Disease	Yes	No
Retinal Detachment	Yes	No
Eye Injury		
Eye Surgery		

Medical History
Do you or have you had:

Diabetes	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Asthma	Yes	No
Heart Condition	Yes	No
Kidney Stones	Yes	No
Pacemaker	Yes	No
High Blood Pressure	Yes	No
Low Blood Pressure	Yes	No
Fainting Spells	Yes	No
Headaches	Yes	No
Hay Fever	Yes	No
Thyroid	Yes	No
Arthritis (Osteoarthritis / Rheumatoid)	Yes	No
Cancer	Yes	No
AIDS/HIV	Yes	No
Hepatitis	Yes	No
Do you drink alcohol?	Yes	No
Do you smoke?	Yes	No
Do you use drugs?	Yes	No
Are you pregnant?	Yes	No
Allergy to Medicines?	Yes	No

If yes, please list: _____

_____

_____

Please list previous Surgeries: _____

_____

_____

Family History:

Blindness	Yes	No
Glaucoma	Yes	No
Macular Disease	Yes	No
Diabetes	Yes	No
Migraine	Yes	No
Hypertension	Yes	No
Heart Condition	Yes	No
Cataracts	Yes	No
Asthma	Yes	No
Other		

Please list ALL CURRENT Medications including eye drops:

_____

_____

_____

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