Benson Vision Source

Thomas Mitchell, OD

Today's Date: _____/_____/_____
Last Name: _____
First Name: _____MI_____
Street: _____
City: _____State: _____
Zip Code: _____ Age: _____
Date of Birth: _____ Sex: M or F
Cell Phone: _____ OK to Text? Y or N
Work Phone: _____
Home Phone: _____
Email Address: _____
If under 18, Guarantor: _____
Employer (or School) _____
Occupation (or Grade) _____
What brings you in today? _____
_____
_____

IF NEW PATIENT:
How did you hear about us?
____ Insurance Directory _____ Friend
____ Internet _____ Family
Referred by: _____

INSURANCE INFORMATION:
Primary Vision Carrier:
_____
Subscriber Name: _____
Subscriber SSN: _____
Subscriber DOB: _____
Primary Medical Carrier:
_____
Subscriber Name: _____
Subscriber SSN: _____
Subscriber DOB: _____
<u>Secondary</u> Vision Carrier:_____
Subscriber Name: _____
Subscriber SSN: _____
Subscriber DOB: _____
<u>Secondary</u> Medical Carrier: _____
Subscriber Name: _____
Subscriber SSN: _____
Subscriber DOB: _____

MEDICAL HISTORY:
Primary Care Physician: _____
Location/Clinic: _____
Date of last Physical/Check: _____
CURRENT MEDICATIONS (Rx or Over the Counter)
(List the name of med including eye drops, vitamins & birth control pills and what they treat)
_____ _____
_____ _____
_____ _____
_____ _____

Has a **<u>blood relative</u>** ever been diagnosed with the following? If yes, what is their relationship to you?
Blindness Y / N _____
Cataracts at young age Y / N _____
Corneal Problems Y / N _____
Diabetes Y / N _____
Glaucoma Y / N _____
Heart Disease Y / N _____
Lazy Eye Y / N _____
Macular Degeneration Y / N _____
Retinal Problems Y / N _____
Are you nursing or pregnant Y / N
Any allergies to Medications Y / N, if so what medications _____
_____
Reaction? _____
Do you use Cigarettes/Tobacco Y / N Alcohol Y / N
Heroin Y / N Meth Y / N Opiates Y / N
Height _____ Weight _____

Have you ever been diagnosed or treated for the following health problems ?

Allergies	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Unusual weight loss/gain	Y	N
Diabetes / Endocrine	Y	N
Thyroid	Y	N
Digestive	Y	N
Genitourinary	Y	N
Kidney	Y	N
Ears/Nose/Throat	Y	N
Blood/Lymph	Y	N
Immunologic	Y	N

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Skin/Eczema/Rashes	Y	N
Arthritis	Y	N
Neurological	Y	N
Psychological	Y	N
Respiratory	Y	N
Cancer	Y	N

Explain: _____

_____

_____

_____

Do you . . . (check the circle if your answer is yes)

- o Work on a computer for longer periods of time
- o think you might prefer a thinner, lighter lens
- o have interest in a 1 week trial of contact lenses
- o spend time outdoors? How much _____ hrs/wk
- o have prescription sun wear
- o enjoy fishing, boating or skiing
- o prefer not to wear your glasses all the time
- o have more than 1 pair of prescription glasses
- o have children or other family needing eye care
- o If you wear lined bifocals, does the line bother you Y / N

Have you recently experienced, been diagnosed or treated for any of the following? (please circle)

Blurry Vision	Cataracts
Burning Eyes	Crossed eye/eye turn
Occasional dryness	Corneal Abrasions
Tearing	Eye Infections
Double Vision	Eye Injury
Flashes of Light	Glaucoma
Floaters/Spots	Macular Degeneration
Grittiness	Retinal Detachment
Headaches	Iritis/Uveitis
Itchiness	Lazy Eye
Sunlight Sensitivity	Other eye disorders
Trouble seeing/driving at night	Glasses Uncomfortable

Date or your last eye health exam _____

Where/By Whom? _____

Do you wear glasses for (circle) Distance, Near, Bifocal

Have you ever tried contact lenses? Y / N

If you wear Contacts, what brand? _____

What solution do you use? _____

(2016nppaperwork-ta)

Are you satisfied with the vision and comfort of your contact lenses currently? Y / N

Would you prefer contacts that do not require daily cleaning? Y / N

Signature on file:

I authorize release of any information to my insurance company necessary to process a claim; I authorize payment to be made directly to Benson Vision Source /Dr. Thomas Mitchell; I authorize use of this form on all of my insurance submissions and permit a copy of this authorization to be used in place of the original; **I understand there is a difference between my Medical insurance being billed, due to a medical diagnosis found during my exam and my Routine Vision insurance being billed, if my exam is routine;** I understand that I am responsible for payment of any charges not paid for by my insurance, including any cop-payments not collected at time of order; I understand this office does not in any way guarantee payment for services/eyewear by accepting my insurance plan and that all insurance benefit amounts quoted are estimates received from your insurance company and actual amount due from you may change after insurance claim processing.

****I have also read, or been offered a copy of Benson Vision Source's HIPPA Privacy Practices.**

I also acknowledge any Glasses out of pocket, Co-pays, Retinal Photo, Renewal Fees of Contact Lens Rx (Contact Lens Evaluation) are due today, at time of service. There is a $25 NSF check fee and a late fee of $20 if Statements are paid after 30 days.

Signed:

_____

Date: _____

NONE OF MY HEALTH HISTORY HAS CHANGED

Signature: _____Date: _____

I am refusing to fill out or sign the paperwork offered by Benson Vision Source today.

Signed:

_____

Date: _____