WELCOME TO OUR OFFICE

BENGOA EYE CARE

Our Mission: We are a team of professionals dedicated to providing our patients, from infants to seniors, with the highest quality vision and eye care.

Today's Date _____

Patient Information

Last Name _____
First _____ MI _____
Preferred First Name _____
Mailing Address _____
City _____ State _____
Zip Code _____
Home Phone _____
Work Phone _____
Cell Phone _____
Email Address _____
How you'd prefer to be contacted (#1 & #2 Choice):
Home #___ Work #___ Cell #___ Mail___ Email___
Patient's SSN _____
Date of Birth _____ Age _____
Sex M ❑ F ❑
Employer (or School) _____
Occupation (or Grade) _____
Marital Status ❑ Single ❑ Married ❑ Divorced
❑ Separated ❑ Widowed
Preferred Language ❑ English, ❑ Spanish, Other_____
Spouse (or Parent's) Name _____
Spouse (or Parent's) Work _____
Emergency Contact _____
Phone # _____

Some eye conditions occur more often in certain races.
Please indicate your race:
❑ American Indian or Alaska Native ❑ Asian
❑ Black or African American ❑ Hispanic
❑ Native Hawaiian/Other Pacific Islander
❑ White/Caucasian

Major purpose of this visit: _____
Any problems with your current glasses or contacts:
_____

How did you choose our office (check all that apply)
❑ Previous patient of Dr. Bengoa's
❑ Referred by: _____
❑ Another doctor, if so, name: _____
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper
❑ Yellow Pages
❑ Our Web Page (www.BengoaEyeCare.com)
❑ Other _____

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber SSN _____
Subscriber Birth Date _____

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card

***Some medical insurance companies, including Medicare, do not cover a refraction. This is necessary to determine your glasses prescription. You would be responsible for payment. Do you want the refraction performed? ❑ Yes ❑ No**

Lifestyle Questions

Do you……(check box if your answer is yes)
❑..work at a computer? If yes, avg. hours a day: ____
❑..have an interest in thinner, lighter lenses?
❑..spend time outdoors? If yes, avg hours a day: ____
❑..have prescription sunglasses?
❑..have an interest in wearing contact lenses?
❑..want information on Laser Vision Correction surgery?
❑..have more than 1 pair of current Rx eyewear?
❑..have family members in need of eye care?

To best fit your visual needs, please list hobbies, sports, & recreational activities in which you participate:
_____
_____

Have you ever experienced, been diagnosed or treated for any of the following?

❑ Blurry Vision	❑ Burning
❑ Cataracts	❑ Crossed eye/Eye turn
❑ Double Vision	❑ Drooping Eyelid
❑ Eye Infections	❑ Eye Injuries/Trauma
❑ Eye Surgeries	❑ Flash of light
❑ Floaters/Spots	❑ Glaucoma
❑ Grittiness/Dryness	❑ Headaches
❑ Holding reading too close	❑ Iritis/Uveitis
❑ Itchiness	❑ Lazy Eye (Amblyopia)
❑ Loss of place reading	❑ Macular Degeneration
❑ Retinal Detachment	❑ Reversing letters/ or #'s
❑ Sunlight Sensitivity	❑ Tearing
❑ Trouble seeing at night	❑ Uncomfortable glasses
❑ Tracking problem	

❑ Other eye disorders _____

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Medical History

Family Physician's Name_____
City_____
Last Physical Exam Date_____
Surgeries_____

CURRENT MEDICATIONS, Rx & over-the-counter, including eye drops, vitamins, & birth control pills

_____
_____
_____

List any **allergies** to medications_____
_____

Problems with anesthesia? ❑ Yes ❑ No

Tobacco use can affect eye health. Please indicate if you:
❑ Never smoked ❑ Formerly smoked
❑ Currently smoke daily ❑ Current smoke somedays
❑ Currently use smokeless tobacco (chew, snuff)

Do you drink alcohol? ❑ No ❑ Social use only
❑ 1-2 drinks daily ❑ More than 2 drinks daily
Do you use illegal drugs? ❑ Yes ❑ No
Have you ever been exposed to or infected with:
❑ Gonorrhea ❑ Hepatitis ❑ HIV
❑ Syphilis ❑ TB (Tuberculosis)
Ever had a blood transfusion? ❑ Yes ❑ No
Any difficulty when driving:_____
If female: pregnant or nursing? ❑ Yes ❑ No

Any problems with:	**Yes**	**No**
Allergies/Hayfever	❑	❑
Arthritis	❑	❑
Asthma	❑	❑
Blood/Lymph	❑	❑
Bronchitis	❑	❑
Cancer	❑	❑
COPD	❑	❑
Depression	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Eczema/Rashes	❑	❑
Emphysema	❑	❑
Fatigue	❑	❑
Fevers	❑	❑
Genitourinary	❑	❑
Head or Neck injuries	❑	❑
Headaches	❑	❑
Heart disease	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Kidneys	❑	❑
Muscles/Bones	❑	❑
Seizures	❑	❑
Sinuses	❑	❑
Stroke	❑	❑
Thyroid	❑	❑

Other medical conditions _____

Patient Eye History

Last Eye Exam Date_____
By Whom?_____

Have you ever tried contact lenses? ❑ Yes ❑ No
Do you currently wear contact lenses? ❑ Yes ❑ No
What kind?_____
Solutions used_____
How often replaced_____
Need an updated contact lens Rx? ❑ Yes ❑ No
Satisfied with vision and comfort? ❑ Yes ❑ No
Sleep with contact lenses on eyes? ❑ Yes ❑ No
Contact lens preference: ❑ Clear ❑ Colored ❑ Both

If you wear bifocals, do the lines or head tilting bother you?
❑ Yes ❑ No

Family Medical/Eye History (Check all that apply)

List Relationship to You
(include maternal or paternal):

❑ Blindness _____
❑ Cataracts _____
❑ Corneal Problems _____
❑ Glaucoma _____
❑ Eye Turn _____
❑ Lazy Eye (amblyopia) _____
❑ Macular Degeneration_____
❑ Retinal Problems _____
❑ Diabetes _____
❑ Heart Disease _____
❑ High Blood Pressure _____
❑ Lung Conditions _____

❑ None

Not all services are a covered benefit in all insurance contracts. Some insurance companies arbitrarily select certain services they will not cover (e.g. refraction).

If your insurance company has not reimbursed our office in full within 90 days, you are responsible for providing payment in full to Bengoa Eye Care.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Bengoa Eye Care to release all information necessary to secure the payment of benefits.

_____
PATIENT'S NAME

_____ _____
SIGNATURE (Patient or Guardian) Date

BENGOA EYE CARE