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 at Bengoa Eye Care
❑ 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 ❑ Currently 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, type(s)_____		
COPD	❑	❑
Depression	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Eczema/Rashes	❑	❑
Emphysema	❑	❑
Fatigue	❑	❑
Fever	❑	❑
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).

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