



BENGOA EYE CARE

WELCOME TO OUR OFFICE

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?

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Crossed eye/Eye turn |
| <input type="checkbox"/> Double Vision | <input type="checkbox"/> Drooping Eyelid |
| <input type="checkbox"/> Eye Infections | <input type="checkbox"/> Eye Injuries/Trauma |
| <input type="checkbox"/> Eye Surgeries | <input type="checkbox"/> Flash of light |
| <input type="checkbox"/> Floaters/Spots | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Grittiness/Dryness | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Holding reading too close | <input type="checkbox"/> Iritis/Uveitis |
| <input type="checkbox"/> Itchiness | <input type="checkbox"/> Lazy Eye (Amblyopia) |
| <input type="checkbox"/> Loss of place reading | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Reversing letters/ or #'s |
| <input type="checkbox"/> Sunlight Sensitivity | <input type="checkbox"/> Tearing |
| <input type="checkbox"/> Trouble seeing at night | <input type="checkbox"/> Uncomfortable glasses |
| <input type="checkbox"/> Tracking problem | |
| <input type="checkbox"/> 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 some days
 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	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Rashes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Head or Neck injuries	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>
Muscles/Bones	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Sinuses	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
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

