Welcome to

Benbrook Family Vision Care

Phillip G. Hanson, O.D. Director

Patient Information Sheet

Today's Date: ________________

Name (Mr./Mrs./Ms.) ______________________________ Nickname ____________________

Date of Birth ____________________ Social Security Number ____________________

Address ____

City ____________________ State ______ Zip Code ____________________

Home Phone ____________________ Work Phone ____________________

E-Mail ____________________ Cell Phone ____________________

Occupation ____________________ Employer/School ____________________

How did you hear about our office? ____

Family Members Names and Ages

____________________ ____________________

____________________ ____________________

____________________ ____________________

Responsible Party Information
(For patients under 18 years of age)

Name ____________________ Relationship to Patient ____________________

Date of Birth ____________________ Social Security Number____________________

Address ____

City ____________________ State ______ Zip Code ____________________

Home Phone ____________________ Work Phone ____________________

E-Mail ____________________ Cell Phone ____________________

Occupation ____________________ Employer/School ____________________

Privacy Practices And Financial Responsibility

I acknowledge that a copy of Benbrook Family Vision Care's Notice of Privacy Practices has been made available to me. I agree to be responsible for any fees incurred as a result of failure to pay for all services and/or materials provided, including reasonable collection fees.

Signature ______________________________ Date ____________________

Please circle one: Parent or Guardian

Emergency Contact Information

(Not in the Same Household)

Name ______________________ Relationship to Patient ______________________

Address ______________________

City ______________________ State ____________ Zip Code ____________

Home Phone ______________________ Work Phone ______________________

E-Mail ______________________ Cell Phone ______________________

Financial Responsibility (Insurance)

We will be happy to file your insurance claim forms or to take assignment of your vision and/or medical benefits as designated by your insurance company. We are happy to provide this service without any additional charge to you. We will do all that we can to help you receive the maximum benefits.

We go to great lengths to verify the amount and type of coverage you are allowed under your plan. We can quote your estimated coverage, however, final determination of your benefits will not occur until the insurance company receives your claim. In the event the Plan Sponsor determines that you are not eligible at the time of service, makes a determination that you are eligible for a reduced level of coverage, or applies the charges to your deductible, by signing this statement, you agree to be financially responsible for any and all of the charges incurred by you and not paid by the plan sponsor.

Signature ____

Please circle one: Patient or Guardian

Vision Insurance Information

Name ______________________ Relationship to Patient ______________________

Date of Birth ______________________ Social Security Number ______________________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Member Employer ______________________ Name of Insurance Company ______________________

Member ID ______________________ Group Number ______________________

Medical Insurance Information

Name ______________________ Relationship to Patient ______________________

Date of Birth ______________________ Social Security Number ______________________

Home Phone ____________ Work Phone ____________ Cell Phone ____________

Member Employer ______________________ Name of Insurance Company ______________________

Member ID ______________________ Group Number ______________________

Medical History Questionaire

Name ______________________ Date of Birth ________ Today's Date ______________________

Please assist us in providing with the most up to date eye care available by telling us a little about your health history

What brings you in to see us today? Please circle all that apply.

Eye Exam Laser Vision Correction New Glasses New Contacts Other

When was your last eye exam? ______________ Name of the eye Doctor ______________________

Are you currently wearing contact lenses? Yes No   Have you ever worn contact lenses Yes No

Have you noticed any changes in your vision with your correction on? Yes No If yes, do you notice it more in your distance vision, your near vision, or both? Distance Near

When was your last physical? ____________ What is your family doctor's name? ______________________

On average, how many hours a day do you use a computer? ______________________

Patient's Medical History

Please circle Y (Yes) below if You Currently have any of the following or N (No) if you don't.

Constitutional
Y N Weight loss/gain

Ears/Nose/Throat
Y N Sinus Congestion
Y N Dry Throat/Mouth

Cardiovascular
Y N Heart Pain
Y N High Blood Pressure
Y N Vascular Disease
Y N Heart Surgery

Respiratory
Y N Asthma
Y N Chronic Bronchnitis
Y N Emphysema

Genitourinary
Y N Dialysis, Kidney Failure

Gastrointestinal
Y N Diarrhea
Y N Constipation

Musculoskeletal
Y N Rhueumatiod Arthritis
Y N Muscle Pain
Y N Joint Pain

Integumentary(Skin)
Y N Eczema, Skin Cancer

Neurological
Y N Headaches
Y N Migraines
Y N Seizures

Psychiatric
Y N Depression, Anxiety

Endocrine
Y N Diabetes
Y N Hyper/Hypo Throid

Hematologic/Lymphatic
Y N Anemia
Y N Bleeding Problems

Allergic/Immunologic
Y N Lupus
Y N Allergies/Hay Fever

Eyes
Y N Glaucoma
Y N Cataracts
Y N Diabetic Retinopathy
Y N Macular Degeneration
Y N Retinal Disease
Y N Eye/Head injury
Y N Blindness
Y N Strabismus
Y N Lazy/Crossed eyes
Y N Amblyopia
Y N Tired Eyes
Y N Decreased Vision
Y N Dryness
Y N Burning
Y N Itching
Y N Double Vision
Y N Eye Pain
Y N Floaters or Light Flashes
Y N History of Eye Surgeries

Family Medical History

Please circle Yes (Y) if anyone in your family has a history of the following or No (N) if they do not.

Y N Glaucoma If yes, please list their relation to you.______________________
Y N Cataracts If yes, please list their relation to you.______________________
Y N Diabetes If yes, please list their relation to you.______________________
Y N Macular Degeneration If yes, please list their relation to you.______________________
Y N Retinal Disease If yes, please list their relation to you.______________________
Y N Heart Disaese If yes, please list their relation to you.______________________
Y N Thyroid disease If yes, please list their relation to you.______________________
Y N Crossed Eyes If yes, please list their relation to you.______________________
Y N High Blood Pressure If yes, please list their relation to you.______________________
Y N Arthritis If yes, please list their relation to you.______________________

Are you taking any medications (including eye drops) Yes No If so, please list the name and purpose of the medication.

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Do you have any allergies to medications? If so, please list them below.

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If you have concerns that have not been addressed that you would like Doctor Hanson to be aware of, please list them here.

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