Patient Information

Thank you for choosing our practice for your eyecare needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.
(Please Print)

Name_____ **Social Security #**_____ Date_____
First MI Last

Address_____ City_____ State_____ Zip___

Birthdate_____ Home Phone #_____ Work Phone #_____

Cell Phone #_____

Do you prefer to receive calls at: □Home □Work □Either □Email_____

Are you: □Minor □Married □Divorced □Widowed □Single □Separated

Employer_____ Occupation_____

Business Address_____ City_____ State_____ Zip___

Spouse or parent name_____ Workplace_____ Work phone #_____

Person to contact in case of emergency_____ Phone #_____

Whom may we thank for referring you to us?_____

Responsible Party

Name of person responsible for this account_____ SS#_____

Relationship to patient_____ Phone #_____

Address_____ City_____ State_____ Zip___

Name of employer_____ Work phone #_____

Insurance Information

Are you on Disability Insurance? □Yes □No If retired, are you still working? □Yes □No

Vision Insurance

Name of insured_____ Relationship to patient_____

Birthdate_____ Social Security #_____ Date employed_____

Address_____ City_____ State_____ Zip_____

Insurance Co._____ Group #_____ Employer #_____

Insurance Co. Address_____ City_____ State_____ Zip_____

Health Insurance

Name of insured_____ Relationship to patient_____

Birthdate_____ Social Security #_____ Date employed_____

Address_____ City_____ State_____ Zip_____

Insurance Co._____ Group #_____ Employer #_____

Insurance Co. Address_____ City_____ State_____ Zip_____

Primary Care Physician/ Family Doctor_____

Please Complete Other Side

Health History

Reason for today's exam_____

_____

_____

Date of last eye exam_____ Name of last eye doctor_____

Does anyone in your immediate family have a history of the following? (if so, please mark who)

□Diabetes	□Blindness	□Macular Degeneration
□High Blood Pressure	□Cataracts	□Lazy Eye
□Heart Condition	□Glaucoma	

Please check any of the following that apply to you:

□Diabetes □Type I □Type II	□Epilepsy/ Seizure Disorder	□Glaucoma
□High Blood Pressure	□Blindness	□Macular Degeneration
□Heart Condition	□Cataracts	□Lazy Eye
□Other Medical Condition(s)_____		

□Poor Distance Vision	□Sensitivity to light	□Double Vision
□Poor Near Vision	□Floaters or spots	□Eye Infection (or disease)_____
□Eye Injury	□Eye strain	_____
□Eye itch, burn or tear	□Eye Surgery_____	

Please list **ALL** medications (including eye drops) you are currently taking_____

_____

_____

Do you have **any** allergies?_____

Are you allergic to **any** medications?_____

Do you currently wear glasses? □Yes □No

When do you wear your glasses?

□All the time	□Reading/ near work
□Work safety	□Distance tasks only
□Computer work	□Other, please explain_____

Are you interested in contact lenses? □Yes □No

Have you ever worn contacts? □Yes □No

□Soft	□Extended Wear	□Gas Permeable	□Bifocal
□Tinted	□Astigmatic/ Toric	□Disposable	□Unsure

Are you interested in Laser Vision Correction? □Yes □No

Do you work on a computer? □Yes □No □Desktop □Laptop

What hobbies or sports do you participate in?_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to my or my child during the period of such eyecare to third part payers and/ or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me. I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

SIGNATURE OF PATIENT (Or parent if a minor)

Please Complete Other Side

Signature on File, Assignment of Benefits, Financial Agreement

Beneficiary Name (print)	Insurance Company	Insurance ID Number

1) ***Medicare:*** I request that payment of authorized Medicare benefits be made on my behalf to ***Bennett EyeCare Midwest*** for services furnished me by ***Bennett EyeCare Midwest***. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefit payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. ***Bennett EyeCare Midwest*** accepts the charge determination of the Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

2) ***MediGap:*** I understand that if a MediGap policy or other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes release of the information to the insurer or agency shown. I request that payment of authorized secondary insurance benefits be made on my behalf to ***Bennett EyeCare Midwest***, if possible or otherwise to me.

3) ***Release of Information: Bennett EyeCare Midwest*** may disclose all or any part of my medical record and/or financial ledger, including information regarding alcohol or drug abuse, psychiatric illness, communicable disease, or HIV, to any person or corporation (1) which is or may be liable or under contract to ***Bennett Eyecare Midwest*** for reimbursement for services rendered, and (2) any health care provider of continued patient care. ***Bennett EyeCare Midwest*** may disclose on an anonymous basis any information concerning my case, which is necessary or appropriate for the advancement for medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, statute or regulation. A copy of this authorization may be used in a place of the original.

4) ***Other Insurance:*** I understand that ***Bennett Eyecare Midwes***t maintains a list of health care service plans with which it contracts. A list of such plans is available from the business office and that ***Bennett EyeCare Midwest*** has no contract, expressed or implied, with any plan that does not appear on the list. The undersigned agrees that I am individually obligated to pay the full charges of all services rendered to me by ***Bennett EyeCare Midwest*** if I belong to a plan that does not appear on the above mentioned list.

5) ***Non-Covered Services:*** I understand that ***Bennett EyeCare Midwest's*** contracts with health care service plans (i.e., HMOs, PPOs) relate only to items and services, which are covered by the health care service plans. Accordingly, the undersigned accepts full financial responsibility for all items or services, which are determined by the health care service plans not to be covered. Examples of non-covered services include, but are not limited to, services not specified as being covered in the patient's contract with a health care service plan or in the benefit summary the health care service plan furnishes to the patient and treatment or tests not authorized by the health care service plan. The undersigned agrees to cooperate with ***Bennett Eyecare Midwest*** to obtain necessary health care service plan authorizations.

6) ***Financial Agreement:*** I agree that in return for the services provided to the patient by ***Bennett Eyecare Midwest***, I will pay my account at the time service is rendered or will make financial arrangements satisfactory to ***Bennett Eyecare Midwest*** for payment. If an account is sent to an attorney or collections, I agree to pay collection expenses and/or reasonable legal fees as established by the court and not by a jury in any court action. I understand and agree that if my account is delinquent, I may be charged interest at the legal rate. Any benefits of any type under any policy of insurance insuring the patient, or any other party liable to the patient, is hereby assigned to ***Bennett Eyecare Midwest***. However, it is understood that the undersigned and/or the patient are primarily responsible for the payment of my bill.

At ***Bennett Eyecare Midwest*** we strive to enforce HIPAA security policies. Our offices will have updates on HIPAA compliances as deemed necessary. We will continually keep your privacy secure at all times and address the security of electronic health information systems. Providers and health plans are required by HIPAA to enforce complete privacy standards. Each provider has assigned NPI, plan, and provider group identification numbers to prevent fraud.

Bennett Eyecare Midwest will never sell or use your information in a fraudulent manner. You may read the complete HIPAA regulations online at www.cms.hhs.gov/hipaa. If you do not have access to a computer, a staff member will be happy to print a copy for you.

_____ _____

Beneficiary Signature or Authorized Party Date