

# Bethelview Eyecare Patient Update

\*\*Please update with correct insurance information\*\*

Please turn ALL phones off. Computers, head sets and games may be used only in reception area.

Date: \_\_\_\_\_  
Legal Name: \_\_\_\_\_ Preferred: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
St \_\_\_\_\_ Zip \_\_\_\_\_ Phn#: \_\_\_\_\_ Altent# \_\_\_\_\_

**Marital Status:** Married Single Divorced Widowed

**Employment:** Full Tm Part Tm Student Retired Home-Maker

Have there been any changes in your **health** or **vision** since your last visit? (If so please explain)

**Pregnant:** Yes/ No **Trimester:** 1<sup>st</sup> 2<sup>nd</sup> 3<sup>rd</sup> **Gestational Diabetes** Yes/ No

**Personal Family History of Diabetes:** Yes/ No

Please list **all** medications and treatments: \_\_\_\_\_

Any questions or concerns for the Dr. Today? \_\_\_\_\_

## Reason for Visit:

- Routine Exam     Infection/ Irritation     Glasses     Contacts ( Soft  Hard)  
 Previous Wearer     New Wearer     Follow-up  
 RX Sunglasses     Plain Sunglasses  
**\*Dilation:**  Consent     Decline     will return at a later date

## Insurance Information

Name of Primary Health Insurance: \_\_\_\_\_ Secondary \_\_\_\_\_

Vision Plan \_\_\_\_\_ Primary Card Holder's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Primary DOB: \_\_\_\_\_ Primary's First and Last Name \_\_\_\_\_

**Your relationship to Primary:** Member (self) Spouse Child/Dependent Domestic Partner Handicapped Child

Incorrect Insurance information may result in denial of claims which may leave you financially responsible for your visit. Your Medical and Vision insurance are two different types of insurance. Any further testing will be submitted to your Medical Insurance and will be your responsibility if you have not met your deductible.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian of: \_\_\_\_\_