

BETHELVIEW EYECARE PATIENT QUESTIONNAIRE

Please turn **ALL phones OFF**. Computers, head sets and games may be used **only** in reception room. Thank you.

Last _____ First _____ M _____ DOB: _____ Date: _____
** Patients under 18 years of age you MUST be accompanied by their legal guardian. **
Address: _____ City _____ St _____ Zip _____
Phn# _____ Altrnt# _____
Marital status: _____ Circle: Full-Tm Part-Tm Student Retired Home-Maker
Occupation & Employer _____
Emergency Contact _____ Phn# _____
Reason for visit: _____

Medical Information

How is your general health? Very Poor/Fair/Good /Excellent Family Dr. _____ Phone # _____
List history of problems with these systems: Eyes _____ Gastrointestinal _____
Nervous _____ Ears/Nose/Throat _____ Respiratory _____
Skin _____ Neurological/ Headaches _____ Cardiovascular _____
Musculoskeletal _____ Blood/lymph _____ Allergic/Immunologic _____
Endocrine/ Diabetes _____ Type _____ Date of Diagnosis _____
Cancers: _____ (treatments) _____ Date of Diagnosis _____
Pregnant: Yes/No Trimester 1st 2nd 3rd Gestational Diabetic: Yes/No
Current Meds _____

Family History

Please include maternal/paternal grandparents

Macular Degeneration ___ Relation _____ Retinal Detachment ___ Relation _____
Glaucoma ___ Relation _____ Cataracts ___ Relation _____ Other eye conditions _____
High Blood Pressure ___ Relation _____ Diabetes ___ Relation _____

Personal Eye Information

Date of last exam: _____
Have you ever had any eye operations or eye injuries? _____
Do you have: Glaucoma ___ Cataracts ___ Dry Eyes ___ Blurred Vision ___ Irritation ___
Do you wear (include brand/strength): Glasses _____ Readers _____ Contacts (hard or soft) _____
How did you hear of our office? _____

Reason For Visit:

Routine Exam Glasses Contacts First time wearer of contacts? Corrective Surgery
 RX sunglasses Plain Sunglasses Irritation / Redness in or around eyes: Left / Right / Both
*Insurances require certain procedures & testing to be done for routine examinations. Please check what best applies to you.

*Dilation: Consent Decline will return at a later date.

*Treatment of Routine Vision Screening: Consent Decline 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/ Dependant Domestic Partner Handicapped Child

The information above must be EXACTLY the same as it appears on your insurance card. WE CAN NOT/ WILL NOT file for any services if information is not exact. This, making your visits your financial responsibility and MUST BE PAID IN FULL AT TIME OF SERVICE.

Signature _____ Guardian of: _____ Date _____

The Difference between health insurance and vision insurance

A vision plan provides the member with routine eye examinations, glasses or contact lenses. This is usually a secondary benefit provided to you by your employer or benefits department, in addition to your routine General Health Insurance.

If during this routine exam, the Doctor determines that additional procedures or test are required for the health of your eyes that are not covered by your Vision Plan they will then be YOUR responsibility unless you have provided us with proper medical coverage information.

If we participate in your general health insurance, we will bill these charges for you. You WILL be responsible for any applicable co-payments or deductibles. These charges are above and beyond the coverage provided by your vision plan. If the Doctor determines that additional procedures are necessary, and we do not participate in your general health insurance, you have the option of paying for these services out of network or consulting with your health insurance network to find a participating provider.

There are no refunds or cash refunds on any items such as: co-payments, products supplied by third party providers, or materials, UNLESS the insurance has paid more than the agreed amount. FULL proof of over payment will be needed and be held on record for these situations and a check will be administered to the correct recipient.

I am over the age of 18 or have a parental guardian in my presence so that I understand the information above. By signing below you have given us consent for diagnosis, treatment, and filing for appropriate testing through your insurance or billing you directly for immediate payment.

I sign and acknowledge that I have read and understand this form and the information above.

Signature: _____ Guardian of: _____ date _____