Life is Beautiful. See it!

BENJAMIN EYE INSTITUTE

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New Patient

Patient Information

Title ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. Sex ☐ M ☐ F

Patient
First name _____
Last name _____

D.O.B _____ SS# _____

Address
Street address _____
ZIP Code _____ City _____ State _____

Phone/ Fax
Home Phone _____ Cell Phone _____ Work Phone _____

E-mail _____

Marital status/(check one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Occupation _____

Employer
Name _____ Phone _____

Spouse
Name _____ Employer _____

Insurance Information

Please give your insurance card to the receptionist!

Person responsible for bill _____

D.O.B. _____

Address (if different) _____

Phone/ Fax _____

Is this person a patient here? ☐ Yes ☐ No

Is this patient covered by insurance? ☐ Yes ☐ No

Subscriber
Name _____ D.O.B. _____ SS# _____
Group no. _____ Policy no. _____ Co-payment ($) _____

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable)

Subscriber
Name _____ D.O.B. _____ SS# _____
Group no. _____ Policy no. _____ Co-payment ($) _____

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

In Case of Emergency

Name of local friend or relative (not living at same address) _____

Relationship to Patient _____

Phone
Home Phone _____ Work Phone _____

Date _____ Signature of patient or person acting on patient's behalf _____

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BENJAMIN EYE INSTITUTE

Eye Health History

Physician _____
Name

_____
Date of last visit

Eye Doctor _____
Name

Do you wear glasses? ☐ No ☐ Yes: All the time, Occasionally, Reading, Driving, TV
(Circle as true)

Do you wear contacts? ☐ No ☐ Yes: Type _____ Hours/Day _____

_____
Describe any problems you have with your contacts

Place a mark on Yes or No to indicate if you have had any of the following →

	Yes	No		Yes	No
Bloodshot Eye	☐	☐	Floaters or Spots	☐	☐
Blurred Vision-Distance	☐	☐	Glaucoma	☐	☐
Blurred Vision-Near	☐	☐	Headaches	☐	☐
Burning Eyes	☐	☐	Itching Eyes	☐	☐
Cataracts	☐	☐	Light Sensitive	☐	☐
Color Vision, Poor	☐	☐	Loss of Vision	☐	☐
Crossed Eyes	☐	☐	Migraine Headaches	☐	☐
Discharge from Eyes	☐	☐	Night Vision, Poor	☐	☐
Dizzy Spells	☐	☐	Red Eyes	☐	☐
Double Vision	☐	☐	Seeing Halos	☐	☐
Dry Eyes	☐	☐	Seeing Flashes	☐	☐
Eye Infection	☐	☐	Temporary Loss of Vision	☐	☐
Eye Injury	☐	☐	Twitching Eyelid	☐	☐
Eye Strain	☐	☐	Vision Poor	☐	☐
Fainting Spells. Blackouts	☐	☐	Watering Eyes	☐	☐

Please tell us how you learned of our practice or whom we may thank. →

- ○ I was a Former Patient
- ○ Former Patient recommendation _____ Name
- ○ Doctor recommendation _____ Name
- ○ Family or Friend recommendation _____ Name
- ○ Insurance Company recommendation
- ○ Employer recommendation
- ○ Newspaper advertisement
- ○ Yellow Page advertisement
- ○ Web page _____ Name of the web page
- ○ TV advertisement
- ○ Radio advertisement
- ○ Internet Search Engine _____ Name
- ○ I learned about you another way _____ Please explain
- ○ Are you interested in LASIK?

General Health History

Physician

Name _____ Phone _____

Date of last visit _____

Place a mark on Yes or No to indicate if you have had any of the following.

Also place a mark to indicate if a blood relative has had any of the following problems.

	Yourself		Family Mem.	
	Yes	No	Yes	No
AIDS /HIV	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐
Artificial Heart Valve	☐	☐	☐	☐
Artificial Joints	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Bleeding	☐	☐	☐	☐
Blindness	☐	☐	☐	☐
Cancer	☐	☐	☐	☐
Cataracts	☐	☐	☐	☐
Chemical Dependency	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Drug Sensitivity	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐
Eye Surgery	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐

	Yourself		Family Mem.	
	Yes	No	Yes	No
Heart Condition	☐	☐	☐	☐
Hepatitis (Type____)	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐
Lazy Eye	☐	☐	☐	☐
Lupus	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐
Pacemaker	☐	☐	☐	☐
Poor Color Vision	☐	☐	☐	☐
Retinal Disease	☐	☐	☐	☐
Rheumatic Fever	☐	☐	☐	☐
Shingles	☐	☐	☐	☐
Skin Conditions	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Thyroid Conditions	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Turned Eye	☐	☐	☐	☐

Are you pregnant? ☐ Yes ☐ No

Number of Children _____

Alcohol use ☐ Yes ☐ No

Tobacco use ☐ Yes ☐ No

Medications

Pharmacy

Name _____

Phone _____

List medications you are currently taking, including eye drops

_____

_____

_____

_____

Allergies

List your allergies to medications or other substances

_____

_____

_____

_____

Submission of Insurance Claims

I hereby authorize the Benjamin Eye Institute, and Arthur Benjamin, MD, to furnish any and all information necessary for the processing of insurance claims. This may include providing information, including but not limited to findings, diagnoses, illnesses and accidents to the appropriate third party payers.

Initial

Insurance Payments

I hereby irrevocably assign to Dr. Arthur Benjamin all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

Initial

Copays and Deductibles

I agree to pay all copayments, coinsurance, and deductibles at the time the service is rendered.

Initial

Surgical Center Interest

I am aware that Dr. Benjamin has a less than 1% partnership interest in the Specialty Surgical Center, where he performs cataract and other ocular surgery.

Initial

Bounced Checks

I understand that a $50 fee will be charged for any returned checks.

Initial

Medical Records

Every patient has a FREE access to their medical records through patient portal ONLY

I understand that BEI maintains a state of the art electronic health record . I understand that if ever I need a copy of my records a paper version can be generated. I understand that I will be responsible for the administrative and printing costs associated with production of such a paper record. Thecurrent fee is $125 but may increase in the future without notice. I understand I will be charged such a fee every time I need a copy of my records transferred to me or to another healthcare provider or facility.

Initial

Forms

I understand that I am responsible for administrative costs involved with filling out forms such as DMV form ($35), Diagnosis Letters $150, Disability form $150

Initial

Refraction

Prescription for glasses

I understand that most insurance companies including Medicare don't consider refraction or contact lens fitting a medically necessary and coverable service. I understand that I will be responsible for a charge for refraction, currently $90

Initial

A copy of this authorization shall be considered as valid as the original.

Date _____ Signature of patient or guardian _____

Notice of Privacy Practices

The Notice of Privacy Practices tells you how we may use and share your health records. Please read it.

Acknowledgement

1. We will use and share your health records to treat you and to bill for the services we provide.
2. We will use and share your health records to run our business.
3. We will use and share your health records as required by law.

Your Rights

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your records (fee applies);
2. you have the right to receive a list of whom we have given your health records to;
3. you have the right to ask us to correct a mistake in your health records;
4. you have the right to ask that we not use or share your health records;
5. you have the right to ask us to change the way we contact you.

I have received or have been offered a copy of the above Notice of Privacy Practices.

Consent

I consent to the use and sharing of my health records for treatment, payment, and operation purposes. I know that if I do not consent, you cannot provide services to me.

Medical Records

To provide continuity of my medical care,
I request and I authorize that my medical records may be released to Arthur Benjamin, MD.

I understand that after custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that i may refuse to sign this authorization. My refusal to sign will not effect my ability to obtain treatment; receive payment or eligibility for benefits unless allowed by law. By signing belowl represent and warrant that I have authority to sign this document and authorize the use of disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use of disclosure of this protected health information.

Patient's Signature _____ Date _____

Date _____ Signature of patient or legal representative _____

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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