Bennett Optometry

Ms. Miss Mrs. Mr. Dr. PhD: _____ Date of Birth:_____

Address: _____ Phone: _____

City/State/Zip: _____ Cell Ph: _____

SSN: _____ Email: _____ Gender: ☐ Female ☐ Male

Parents' Name (if minor): _____ ☐ Married ☐ Single ☐ Partner

Employer:_____ Occupation: _____ ☐ Full time ☐ Part time ☐ Student

In accordance with the new healthcare guidelines, we are required to obtain the following information:

Preferred Language: ☐ English ☐ Spanish ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ American Indian or Alaska Native ☐ Black or African American ☐ White ☐ Hispanic ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Not Disclosed

Height: _____Ft. _____In. **Weight:** _____ **Lbs.** **Communication Preferred:** ☐ Phone ☐ Email ☐ Mail ☐ Text

Vision insurance co: _____ Subscriber: _____ DOB: _____

Contract #: _____ ☐ HMO ☐ PPO ☐ Traditional Group #: _____

Medical insurance co: _____ Subscriber: _____ DOB: _____

Contract #: _____ ☐ HMO ☐ PPO ☐ Traditional Group #: _____

Primary care physician: _____ Phone: _____

Preferred pharmacy: _____ Phone: _____

Computer use: ☐ Yes ☐ No How many hours per day: _____ I use computer glasses: ☐ Yes ☐ No

I wear contact lenses: ☐ Yes ☐ No Type: _____ I replace my contacts every: _____ ☐ I am interested in contact lenses

I have had refractive surgery: ☐ Yes ☐ No Type:_____ I am interested in refractive surgery: ☐ Yes ☐ No

When was your last eye exam? _____ Name of previous doctor? _____

Referred by:_____ ☐ Doctor ☐ Friend ☐ Family ☐ Ins co. ☐ Advertisement

Initial agreement v below v

Due to the Health Insurance Portability and Accountability Act your initials & signature are required.

☐ I ***authorize*** any holder of medical information about me to release to my insurance company (s) or its agent (s) any information needed to determine these benefits or the benefits payable for related services. I request that payment of authorized services furnished me, be made on my behalf to Bennett Optometry. I agree to be personally and fully responsible for payment of copays, deductible amounts, non-covered and denied services by my insurance company.

or

☐ I ***decline*** the above information release and am solely responsible for fees. I understand that fees are due at time of service.

and

☐ I ***authorize*** any holder of medical information about me to release and or request my medical information with other health care professionals for the purpose of consultation and referral as appropriate for my health care.

and

☐ I have been provided the Bennett Optometry Privacy Policy. You may request a copy.

I agree to assume prompt financial responsibility for fees for services rendered.
I understand this is a lifetime authorization, unless revoked in writing.

Signature: _____ Relationship to patient: _____ Date: _____