Bentz Eye Center

4820 Okeechobee Blvd • West Palm Beach, FL 33417
Ph. (561)689-5500 • Fax (561)689-5504

Welcome to the Bentz Eye Center.
In order to serve you properly we will need the following information. Please print your name as it appears on your insurance card.
All information will be strictly confidential.

PATIENT INFORMATION: **Date: ____/____/____**

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Miss ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED SEX: M or F

PRIMARY LANGUAGE: ☐English ☐Spanish ☐French ☐Creole ☐Other ____________________

NAME (LAST, FIRST)____

DATE OF BIRTH________/________/________ AGE: ________________

SOCIAL SECURITY # : ________________________ OCCUPATION: ________________________

ADDRESS: ____ APT# ______________

CITY: ________________________________ STATE: ____________ ZIP:____________

HOME PHONE: ________________________ CELL PHONE: ________________________

WORK PHONE: ________________________ EMAIL: ________________________________

PARENT/SPOUSE NAME:____________________PRIMARY PHYSICIAN: ____________________

EMERGENCY CONTACT: ________________________ PHONE NUMBER: ____________________

PRIMARY INSURANCE CARRIER: ______________________ VISION PLAN: ________________

RESPONSIBLE PARTY: ____________________________RELATIONSHIP: ________________
(if other than patient)
SOCIAL SECURITY #: ____________________________ DATE OF BIRTH: ________________

REFERRED BY:____

PLEASE READ: YOU ARE RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME SERVICES ARE RENDERED

ALL INSURANCE & LIFETIME MEDICARE B SIGNATURE AUTHORIZATION FOR SERVICES

I authorize any holder of medical of other information about to release to the Social Security Administration and Health Care Financing Administration any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medic al insurance benefits either to myself or to the party who accepts assignment.

Non-covered services: I understand that certain services, including but not limited to: normal eye exams, refractions (determination of prescription for eyeglasses and contact lenses), contact lenses, supplies, letters, and research, are not covered by Medicare, most insurors, PPOs, and prepaid health plans. I agree to pay for these services personally.

Covered Services: I understand that almost all insurances, Medicare, PPOs and HMOs have a deductible and co-payment which they do not cover. These deductibles and co-payments are my direct responsibility and I will pay for these at the time services are rendered. If it becomes necessary to effect collection of this account, I agree to pay all costs and expenses including designated attorney's fees. I, hereby, verify that I have received the Notice of Privacy Practices.

Patient Signature: ____

(a copy of this signature is as valid as the original)

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PATIENT NAME:____DOB: ____/____/____

WHEN WAS YOUR LAST EYE EXAM? ____________________ DOCTOR'S NAME: ____________________

DO YOU WEAR GLASSES? Y N CONTACT LENSES? Y N BRAND(if known): ____________________

REASON FOR TODAY'S VISIT: ____

____

HOW LONG HAVE YOU HAD THIS PROBLEM?____

HAVE YOU EVER HAD EYE SURGERY? Y N (If yes, please list): ____________________

____

Is there a family history of any of the following eye problems: ☐GLAUCOMA ☐CATARACTS ☐DIABETES ☐MACULAR DEGENERATION ☐RETINAL DETACHMENT ☐ Other ____________________

Do you use:
TOBACCO? N Y ____packs per day ☐Quit ALCOHOL? N Y _____drinks per day/week ☐Quit

PLEASE LIST ALL PREVIOUS SURGERIES:____

____

PLEASE LIST ALL MEDICATIONS OR VITAMINS THAT YOU TAKE:____________________

____

DO YOU USE EYE DROPS? (please list):____

DO YOU HAVE ANY DRUG ALLERGIES? (please list):____________________

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE
☐ HIGH CHOLESTEROL
☐ HEART SURGERY
☐ PACEMAKER
☐ ORGAN TRANSPLANT
☐ ANEMIA
☐ SICKLE CELL ANEMIA
☐ HIV
☐ STROKE
☐ HEARING LOSS
☐ MIGRAINES
☐ CANCER
☐ DIZZY SPELLS
☐ EPILEPSY

☐ EMPHYSEMA
☐ TUBERCULOSIS
☐ SINUS PROBLEMS
☐ ASTHMA
☐ DIABETES
☐ DIALYSIS
☐ ARTHRITIS
☐ HEPATITIS
☐ LUPUS
☐ STOMACH ULCERS
☐ CROHN'S DISEASE
☐ ARTIFICIAL JOINT
☐ PSYCHIATRIC TREATMENT

HAVE YOU EVER TAKEN MEDICATION FOR YOUR PROSTATE?
(Flomax, tamsulosin) Y N

Please list any general health problems for you or your immediate family:

____

____

____

____

Patient Signature: ______________________________________ Date: ____________________