❑ New patient
❑ Update

BENEFIELD EYE CARE, PC

PATIENT INFORMATION

ALL INFORMATION IS STRICTLY CONFIDENTIAL

Your insurance company requires the following information.

We are delighted to see you.

TODAY'S DATE _____ REFERRED BY _____

PATIENT'S NAME _____ BIRTHDATE _____ AGE _____

SOCIAL SECURITY # _____ MARITAL STATUS _____ M F _____

STREET ADDRESS _____

City ▲ State ▲ Zip Code ▲

HOME ( ) ___-____ WORK ( ) ___-____ CELL ( ) ___-____ E-MAIL _____

EMPLOYER _____ ADDRESS _____ ZIP _____

EMERGENCY CONTACT _____ PHONE ( ) _____-_____

NAME OF PARENT / GUARDIAN IF A MINOR _____

SSN # OF PARENT / GUARDIAN OF MINOR _____ DOB OF MINOR'S PARENT / GUARDIAN _____

EMPLOYER OF PARENT / GUARDIAN _____

PARENT / GUARDIAN WORK PHONE _____ CAN WE CALL YOU AT WORK? ❑ YES ❑ NO

PRIMARY INSURANCE COMPANY _____ POLICY # _____

INSURED NAME _____ SSN # _____

IS INSURANCE THROUGH EMPLOYER? ❑ YES ❑ NO GROUP # _____

ANY SECONDARY INSURANCE? _____

WHO IS RESPONSIBLE FOR THIS BILL? _____

ADDRESS OF RESPONSIBLE PARTY _____

City ▲ State ▲ Zip Code ▲

FINANCIAL RESPONSIBILITY AND COMMUNICATION CONSENT: By signing this, you understand that you are financially responsible for all charges and services. This includes the balance remaining after payment of possible insurance benefits. Please note, if your account is turned over to our collection agency, this will be reported to the credit bureau as a negative impact. Patients that are sent to our collection agency will have an additional 35% added to the fee that is owed. This is due to the collection agency charging us 35% to collect the money that is owed from patient to Benefield Eye Care. Understand that in the event that your account is referred to an attorney for collection, you agree to be liable for such additional reasonable court costs and attorney fees as may be determined by a court. I authorize the use of the phone numbers and other contact information I provide, including my cellular number and any future number assigned to me, for calls, texts, emails, to include automated dialers, to contact me regarding my care and my account by Benefield Eye Care and Benefield Eye Care's business associates.

SIGNED _____ DATE _____

Signature of patient (If a minor, parent or guardian's signature is required)

MISSED APPOINTMENT/NO-SHOW POLICY: It is our office policy to do all that we can to help our patients make it to their appointments as scheduled. As a courtesy, we do our best to notify you of your scheduled appointment two days prior via phone call. However it is **NOT THE RESPONSIBILITY** of Benefield Eye Care to remind you of your appointment; it is solely your responsibility to arrive at the scheduled appointments. Missed appointments occur often, and this is lost time for our business as well as for patients who may be in crisis or on a waiting list. Please notify us at least 48 hours prior to appointment if you are not going to make it.

SIGNED _____ DATE _____

Signature of patient (If a minor, parent or guardian's signature is required)

I understand that my pupils may be dilated to diagnose my condition, which could temporarily cause glare and near vision difficulty. It may be necessary to have a driver after being dilated. On rare occasion, adverse reaction may be triggered from the dilating drops, which is treatable with immediate medical attention.

SIGNED _____ DATE _____

Signature of patient (If a minor, parent or guardian's signature is required)

Refraction (glasses examination) is a measurement of the patient's preference for the focusing of the eyes, which may be used to purchase glasses and/or contact lenses. This measurement gives the doctor your best vision, which is an important component of a thorough eye exam. A refraction is not included in the approval fee for an Eye Examination and therefore is billed separately to the patient. I understand that if this service is provided I am responsible for the fee, which currently is $40.00.

SIGNED _____ DATE _____

Signature of patient (If a minor, parent or guardian's signature is required)

BENEFIELD EYE CARE, P.C. - MEDICAL HISTORY QUESTIONNAIRE

CHART # _____

Name: _____ **Date of Birth:** _____ **Age:** _____ **Date:** _____

Height: _____ Weight: _____ Sex: Male/Female Primary Care Physician: _____

CONDITIONS:	Circle any and all that apply to you OR check none.	NONE
GENERAL:	fever, heat stroke, weight loss, weight gain, fatigue, insomnia, headaches	
EARS, NOSE, THROAT:	hard of hearing, ear ache, cough, dry mouth, sinus/allergy hoarseness, vertigo	
CARDIOVASCULAR:	high B/P, heart attack, chest pain, congestive heart failure, racing pulse, high cholesterol, irregular heartbeat, palpitations, pace maker	
RESPIRATORY:	congestion, wheezing, short of breath, asthma, COPD emphysema, TB exposure, pneumonia vaccine ❑ Yes ❑ No	
GASTROINTESTINAL:	stomach upset, diarrhea, constipation, hernia, ulcers, nausea GERD	
GENITOURINARY:	painful/frequent urination, impotence, yellow jaundice, kidney stones blood in urine	
FEMALES:	Are you pregnant? Are you nursing?	
MUSCULOSKELETAL:	joint pain, stiffness, swelling, cramps, fibromyalgia, rheumatoid arthritis, lupus, other type arthritis, osteoporosis	
DERMATOLOGICAL:	pimples, acne, warts, growths, rash, rosacea, melanoma	
NEUROLOGICAL:	numbness, headache, seizures, paralysis, stroke, dementia memory loss, Alzheimer's, Parkinson's	
PSYCHIATRIC:	anxiety, depression	
ENDOCRINE:	diabetes, most recent A1C___, hypothyroid, hyperthyroid, hormone, increased thirst, Graves Disease, Thyroid Eye Disease	
HEMATOLOGY:	bleeding, anemia, blood clots problems related to blood transfusions	
CANCER:	breast, prostate, lung, skin, colon, other	
ALLERGIC/IMMUNOLOGIC:	sinus, sneezing, swelling, redness, itching, hives, lupus, HIV, Herpes Simplex Virus, Sjogren's Syndrome, rheumatoid arthritis	
EYES:	cataract, glaucoma, detached retina, blindness, lazy eye eye injury/trauma, corneal problems, macular degeneration	

List all Eye Surgeries & Laser Eye Surgeries:

_____

_____

List all OTHER surgeries you have had:

_____

_____

FAMILY HISTORY: Has any member of your immediate family (blood relatives) have/had these diseases?

Lazy Eye	yes	no	Mother	Father	Sibling	Grandparent	Heart Disease	yes	no	Mother	Father	Sibling	Grandparent
Macular Degeneration	yes	no	Mother	Father	Sibling	Grandparent	Hypertension	yes	no	Mother	Father	Sibling	Grandparent
Blindness	yes	no	Mother	Father	Sibling	Grandparent	Stroke	yes	no	Mother	Father	Sibling	Grandparent
Retinal Disorder	yes	no	Mother	Father	Sibling	Grandparent	Thyroid Disease	yes	no	Mother	Father	Sibling	Grandparent
Cataracts	yes	no	Mother	Father	Sibling	Grandparent	Arthritis	yes	no	Mother	Father	Sibling	Grandparent
Glaucoma	yes	no	Mother	Father	Sibling	Grandparent	Cancer	yes	no	Mother	Father	Sibling	Grandparent
Diabetes	yes	no	Mother	Father	Sibling	Grandparent	Type of Cancer: _____			Mother	Father	Sibling	Grandparent

Physician Signature: _____ **Date:** _____

All information you provide is confidential and will not be released to anyone without your consent

Use back of form for any additional information that you need to add.

CHART # ______________________

Patient Name: ______________________ Date of Birth: ______________ Date: __________

Due to Medicare laws and regulations, if you are 65 years of age or older, please answer the following question(s):

Do you wish to discuss your advanced care plan with our office?

❑ YES ❑ NO If you marked **YES,** please answer the following questions:

Do you have a health care proxy in the event you are unable to make your own decisions?

❑ YES ❑ NO Designee's Name: ______________________ Designee's phone # ______________

Do you have a living will? ❑ YES ❑ NO

Which statement best reflects your wishes on advanced care recommendations?

❑ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

❑ Do Not Resuscitate: if my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart even if it is necessary to save my life.

❑ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Previous Optometrist/Ophthalmologist: ______________________________

SOCIAL HISTORY:

Circle: Student Homemaker Employed Retired **Circle:** Single Married Separated Divorced Widowed

Do you use Tobacco? Yes / No Cigarettes / Smokeless _____ # Packs/Times a Day_____ # of Years

Do you use Alcohol? Yes / No Rarely Daily Weekly 1-2 drinks 2-4 drinks Other ______________

Substance Abuse? Yes / No Rarely Daily Weekly ______________________

LIST ANY DRUG ALLERGIES: ______________________________

List all Prescription and Over the Counter medications you are taking: (Including Eye Drops)
if you have a list, please give to receptionist to copy in lieu of filling out form:

Medication Name	Dosage	Taken how often? PRN = when needed	Route	Reason for taking	Currently Taking Yes	Currently Taking No	REVIEWED: Staff	REVIEWED: Date
		___ Times a day ___ or PRN	_ Oral _ Topical _ Injection					
		___ Times a day ___ or PRN	_ Oral _ Topical _ Injection					
		___ Times a day ___ or PRN	_ Oral _ Topical _ Injection					
		___ Times a day ___ or PRN	_ Oral _ Topical _ Injection					
		___ Times a day ___ or PRN	_ Oral _ Topical _ Injection					
		___ Times a day ___ or PRN	_ Oral _ Topical _ Injection					
		___ Times a day ___ or PRN	_ Oral _ Topical _ Injection					
		___ Times a day ___ or PRN	_ Oral _ Topical _ Injection					
		___ Times a day ___ or PRN	_ Oral _ Topical _ Injection					

Physician Signature: ______________________________ Date: ______________

All information you provide is confidential and will not be released to anyone without your consent.
Use back of form for any additional information that you need to add.

Benefield Eye Care, PC •14225 Dedeaux Road • Gulfport, MS 39503

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
-

May we call you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

NAME	RELATIONSHIP TO PATIENT	PHONE NUMBER

This consent was signed by: _____ Date: _____

Printed Name of patient or responsible party (relationship)

Signature: _____ Date: _____.

Witness: _____ Date: _____

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Nondiscrimination Statement

Benefield Eye Care, PC complies with all applicable Federal Civil Rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

I have been informed of the Nondiscrimiation Statement and may request a copy of the complete statement at the above address.

Printed Name: _____ Signature: _____ Date: _____

PATIENT RECORD OF DISCLOSURES (Staff Use Only)

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of Protected Health Information (PHI) and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healcare entities must keep records of PHI disclousres. Information provided below, if completed propery, will constitue an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

RECORD OF DISCLOSURES OF PROTECTED HEALTH INFORATION						
DATE	Disclosed to Whom (Address or Fax)	(1)	Description of Disclosure / Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) – Check this box if the disclosure is authorized

(2) – Type Key: T=Treatment Records, P=Payment Information: O=Healthcare Operations

(3) – Enter how disclosure was made: F=Fax, P=Phone, E=Email, M=Mail, O=Other

Do You Experience Dry Eyes?

SPEED I QUESTIONNAIRE

Standardized Patient Evaluation of Eye Dryness Indexed

Benefield EYE CARE

Name_____ **Date** _____

Dry Eye Disease is the most frequent reason that patients visit eye doctors. We are concerned that you may be suffering with this condition as well. Therefore, we ask that you take a few moments and thoughtfully complete the questionnaire below.

Report the **FREQUENCY** of dry eye symptoms you are experiencing by circling NEVER, SOME, OFTEN, CONSTANT.

	NEVER	SOME	OFTEN	CONSTANT
1. Eyes that feel scratchy, gritty or itchy?	0	1	2	3
2. Burning or watering?	0	1	2	3
3. Soreness or irritation?	0	1	2	3
4. Eye fatigue or episodes of blurring?	0	1	2	3

Report the **SEVERITY** of dry eye symptoms you are experiencing by circling NO PROBLEMS, TOLERABLE, UNCOMFORTABLE, BOTHERSOME, INTOLERABLE.

	NO PROBLEMS	TOLERABLE	UNCOMFORTABLE	BOTHERSOME	INTOLERABLE
1. Eyes that feel scratchy, gritty or itchy?	0	1	2	3	4
2. Burning or watering?	0	1	2	3	4
3. Soreness or irritation?	0	1	2	3	4
4. Eye fatigue or episodes of blurring?	0	1	2	3	4

* **Please check if you have experienced symptoms:**

☐ Today ☐ Within the past 72 hours ☐ Within the past 3 months

* **Do you use eye drops and/or ointment?**

☐ YES (If yes add +5 to score) ☐ NO If yes, which drops do you use? _____

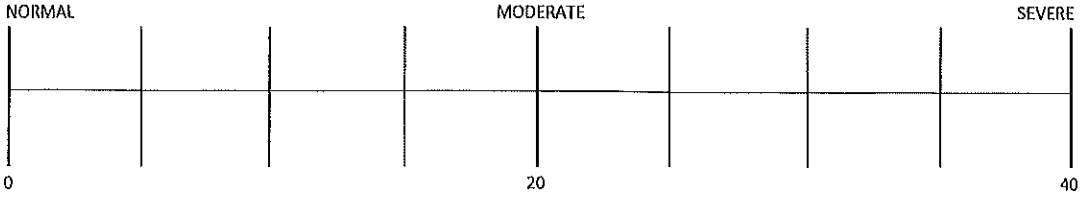
* **Have you ever been told you have blepharitis OR have you been treated for a stye?**

Blepharitis: ☐ YES (If yes add +5 to score) ☐ NO

Stye: ☐ YES (If yes add +5 to score) ☐ NO

* **How would you rate your dry eye severity daily on a scale of 0-10?** _____

DRY EYE SCALE



Total Score:_____

DR/NP _____ Tech_____

cc 3/30/21