Jaclyn Benzoni OD, PC

Thank you for visiting our office!

Name: _____

Address: _____

_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Occupation: _____

Gender: Male or Female Marital Status: _____

Age: _____ Date of Birth: _____

SS#: _____-_____-_____

Referred By: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Pharmacy name and #: _____

Insurance Information

What is your primary medical insurance?

Insurance Name: _____

Subscriber: _____

Subscriber DOB: _____

Relationship to Pt: _____

ID#: _____

Copay Amount: $_____ Referral Needed? YES or NO

What is your secondary medical insurance?

Insurance Name: _____

Subscriber: _____

Subscriber DOB: _____

Relationship to Pt: _____

ID#: _____

Copay Amount: $_____ Referral Needed? YES or NO

Do you have vision/eyeglass/contact lens coverage?

Plan Name: _____

Subscriber: _____

Relationship to Pt: _____

ID#_____

Medical History

Do you have high blood pressure? Y/N: Since what year? _____

Do you have diabetes? Y/N: Since what year? _____

Do you have high cholesterol? Y/N: Since what year? _____

Cardiovascular: Y/N: _____

Endocrine/Thyroid: Y/N:_____

Gastrointestinal: Y/N: _____

Musculoskeletal: Y/N: _____

Neurological: Y/N: _____

Psychiatric: Y/N: _____

Respiratory: Y/N: _____

Other: _____

Medications: (including over the counter): _____

_____

_____

Allergies: _____

Do you smoke: Y/N Primary Care Doctor: _____

Ocular History

Do you currently have or ever had any eye diseases, eye injuries, eye surgery, dry eyes, double vision, or any problems with your eyes? Please describe: _____

_____

_____

Do you wear glasses? Y/N Do you wear contacts? Y/N

Type of contacts: _____ If no, are you interested? Y/N

Is there a family history of glaucoma, diabetes, high blood pressure or any other disease that runs in your family? Please describe:

_____

_____

SIGNATURE ON FILE

I authorize Jaclyn Benzoni OD, PC to use this authorization instead of my actual signature on my insurance submissions. I authorize the release of information to my insurance companies. I authorize payment directly to Jaclyn Benzoni OD, PC when applicable. I understand I am responsible for payment of any charges for all services not covered by insurance companies. I understand that all co-payments must be paid in full on day of services rendered. I have received a copy of the HIPAA polices.

Signature: _____Date:_____

Relationship (if not patient): _____

PLEASE GIVE US YOUR INSURANCE CARDS SO THEY CAN

BE RECORDED INTO YOUR CHART