

**INSURANCE BENEFITS VERIFICATION FORM**

PATIENT'S NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_/\_\_\_/\_\_\_ PATIENTS SOC. SEC # \_\_\_\_\_

PATIENTS ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

PATIENTS MARITAL STATUS (CIRCLE) SINGLE MARRIED DIVORCED WIDOWED

RESPONSIBLE PARTY'S NAME \_\_\_\_\_

RESPONSIBLE PARTY'S ADDRESS \_\_\_\_\_

POLICYHOLDER'S NAME \_\_\_\_\_

POLICY HOLDER # OR SOC. SEC. # \_\_\_\_\_

VISION INSURANCE COMPANY \_\_\_\_\_

INSURANCE CO. PHONE \_\_\_\_\_

GROUP POLICY # \_\_\_\_\_

SUBSCRIBER'S EMPLOYER \_\_\_\_\_

EMPLOYER'S PHONE NUMBER \_\_\_\_\_

In order to recommend the best type of vision correction for you, it is helpful to know how you use your eyes. What is your occupation? \_\_\_\_\_

What are your hobbies or sport activities? \_\_\_\_\_

I, the undersigned, assign directly to **SOLBERG EYE CARE, S.C.** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid for by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits (under HIPPA guidelines). I authorize the use of this signature on all my insurance submissions.

\_\_\_\_\_  
(signature of responsible party)

\_\_\_\_\_  
(Date)

**Could you please answer the following questions to help us serve you?**

Are you considering purchasing glasses at the time of your exam?	YES	NO	MAYBE
Are you considering purchasing contact lenses?	YES	NO	MAYBE
Would you like information on lasik (laser vision correction)?	YES	NO	MAYBE

## PATIENT HEALTH HISTORY FORM

PATIENT NAME \_\_\_\_\_ LAST EYE EXAM \_\_\_\_\_

FAMILY PHYSICIAN \_\_\_\_\_ OFFICE/CLINIC \_\_\_\_\_

Please explain if you ever had eye infections, eye diseases, eye injuries, or eye surgeries

\_\_\_\_\_

List any medications you are allergic to: \_\_\_\_\_

Please list any medications you are taking: NONE \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please check any of the following you presently experience:

### EYES:

_____ headaches	_____ migraines	_____ blurred vision
_____ poor night vision	_____ glare	_____ light sensitivity
_____ loss of vision (temporary or permanent)	_____ double vision	_____ tired eyes
_____ excess tearing	_____ mucous discharge	_____ dryness
_____ burning	_____ sandy/gritty feeling	_____ itching
_____ eye pain/soreness	_____ redness	_____ sty(e)s
_____ flashes of light	_____ floaters (floating spots)	_____ cataracts
_____ crossed eye(s) / lazy eye(s)	_____ macular degeneration	_____ glaucoma

### SYSTEMIC:

_____ diabetes How long? _____		
_____ high blood pressure? How long? _____		
_____ heart problems	_____ allergies	_____ asthma
_____ breathing problems	_____ high cholesterol	_____ hay fever
_____ sinus problems		

Do you smoke YES NO

**FAMILY HISTORY:** Do you have a family member with any of the following conditions?

_____ NONE KNOWN	_____ arthritis
_____ blindness	_____ diabetes
_____ glaucoma	_____ stroke
_____ macular degeneration	_____ high blood pressure
_____ retinal detachment	_____ heart problems
_____ lazy eye(s)	_____ thyroid condition

Is there anything else about your medical history that you think is important for the doctor know? Please explain. \_\_\_\_\_

\_\_\_\_\_