Maple Valley Vision Clinic
Dr. Ryan Bennion / Dr. Scott Bennion

Wilderness Village • 22126 SE 237th St • Maple Valley, WA 98038
Tele. **425-432-1206**• FAX **425-413-4465**

Welcome to our Office!

We dedicate our practice to providing the utmost in quality medical eye care, vision care and preventive treatment. We will strive to maintain the highest levels of service, technology and training to keep our patients seeing their best throughout their lives. We have been serving patients in the Maple Valley, Black Diamond and surrounding areas since 1976.

Today's Date _____

Patient Information

Last _____
First _____ MI _____
Date of Birth _____ Age _____
Sex ❑ M ❑ F
Street _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____
Which number do you prefer we use? Home
Marital Status: Single
Married ❑ Widowed ❑
Patient's SSN _____
Employer (or school) _____
Occupation (or Grade) _____
Spouse (or Parent's) Name _____
Spouse (or Parent's) Work _____
Email Address _____

May we email you with appointment confirmations?
❑ *Yes* ❑ *No*
Are you interested in receiving new product information and office promotions?
❑ *Yes* *No*

Insurance Information

Vision Insurance _____
Subscriber Name _____
Subscriber ID# _____
Subscriber Birth Date _____

Primary Medical Insurance _____
Subscriber Name _____
Subscriber ID# _____
Subscriber Birth Date _____

Do you participate in a flex spending account?
❑ Yes ❑ No
How will you settle your account today?
❑ Cash ❑ Check ❑ Credit Card
Do you have secondary coverage?
❑ Yes ❑ No Name: _____

PLEASE BE ADVISED if you are using insurance coverage for today's visit, this is a contract between you and your insurance company... not Maple Valley Vision Clinic.

If your insurance company has not reimbursed our office in full within 90 days, we will request payment from you and your insurance company will then need to pay you directly. (If by mistake your insurance company sends the payment check to us, we will of course sign over and forward the check directly to you.)

Signature _____

Thank you for choosing our office!

Whom may we thank for referring you to our office?

Name of friend or relative _____

If not referred, how did you choose our office?

❑ Another Dr. _____
❑ Insurance List
❑ Saw Sign/Building
❑ Newspaper
❑ Web Page
❑ Other _____

Please Turn Over And Complete

The information in this confidential case history form is critical to the evaluation of your vision and health.

Patient Information

Name of family physician _____
Date of last physical check-up _____
MEDICATIONS (Rx over-the-counter)
Allergies to medications? ❑ Yes ❑ No
If yes, what medications? _____
_____
(List names of medications including eye drops, vitamins & birth control pills)_____
_____
_____
_____

Have you ever been diagnosed or treated for any of the following health problems?	**Yes**	**No**
Allergies	❑	❑
Arthritis	❑	❑
Blood/Lymph	❑	❑
Cancer	❑	❑
Cholesterol (elevated)	❑	❑
Diabetes	❑	❑
Digestive	❑	❑
Ears/Nose/Throat	❑	❑
Endocrine	❑	❑
Genitourinary	❑	❑
High Blood Pressure	❑	❑
Skin Conditions	❑	❑
Kidney	❑	❑
Muscle/Bone	❑	❑
Neurological	❑	❑
Psychological	❑	❑
Respiratory	❑	❑
Sinus	❑	❑
Thyroid	❑	❑
Unusual Weight losses/gains	❑	❑
Do you use tobacco, alcohol or other substances?	❑	❑
If not now, have you ever used tobacco in the past?	❑	❑
Currently Pregnant	❑	❑

Is there a family medical history of any of the following?

	Relationship
Blindness	❑ _____
Corneal Problems	❑ _____
Diabetes	❑ _____
Glaucoma	❑ _____
Heart Disease	❑ _____
Lazy Eye	❑ _____
Macular Degeneration	❑ _____
Retinal Problems	❑ _____

Patient Eye History / Lifestyle Questions

What is the major purpose of this visit?
_____
_____

Date of last eye exam_____
By whom? _____

Have you ever experienced, been diagnosed with or treated for any of the following?

❑ Blurry Vision	❑ Burning
❑ Cataracts	❑ Corneal Abrasion
❑ Crossed eye/Eye turn	❑ Double Vision
❑ Eye Infections	❑ Eye Injury
❑ Flash of Light	❑ Floaters/Spots
❑ Glaucoma	❑ Grittiness
❑ Headaches	❑ Iritis/Uveitis
❑ Itchiness	❑ Lazy Eye
❑ Macular Degeneration	❑ Occasional Dryness
❑ Retinal Detachment	❑ Sunlight Sensitivity
❑ Watery Eyes	❑ Trouble seeing at night
❑ Uncomfortable Glasses	
❑ Other eye disorders_____	

Have you had any accidents, injuries, or surgeries to your eyes or head? ❑ Yes ❑ No
_____
_____
_____

Do you...(check box if your answer is yes)
❑...work at a computer? How much?____Hrs/day
❑...think you might benefit from thinner, lighter glasses?
❑...spend time outdoors? How much? __ Hrs/week
❑...have prescription sunwear?
❑...have hobbies that require vision?
❑...have interest in a non-surgical approach to vision correction?
❑...have family members in need of eyecare?

Do you currently wear contact lenses? ❑ Yes ❑ No
Have you ever tried contact lenses? ❑ Yes ❑ No
What kind?_____
Are you interested in trying contact lenses? ❑ Yes ❑ No
Solutions used?_____

Are you satisfied with the vision and comfort of your contact lenses? ❑ Yes ❑ No