

Maple Valley Vision and Hearing

Dr. Ryan Bennion / Dr. Scott Bennion
Wilderness Village 23714 222nd PL SE Ste B, Maple Valley, WA 98038
Phone **425-432-1206** / Fax **425-413-4465**

Today's Date: _____

Patient Information

Last Name _____

First Name _____ MI _____

Date of Birth _____

Sex Male Female

SSN _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____

Cell Phone # _____

Which number do you prefer we use? _____

Email Address _____

May we email or text you with appointment confirmations and/or recalls?

Yes No

Spouse/Parent Name _____

Spouse/Parent Phone# _____

Insurance Information

Vision Insurance _____

Subscriber Name _____

Subscriber ID# _____

Subscriber DOB _____

Medical Insurance _____

Subscriber Name _____

Subscriber ID# _____

Subscriber DOB _____

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 and Hearing.

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.

Signature _____

Thank you for choosing our office!

How did you hear about us?

- Friend/Relative? _____
 Insurance Company
 Web page / Social Media
 Saw Building/Sign
 Other _____

Do you have any family members that need vision and/or hearing services?

Yes No

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

Name of family physician : _____
 Date of last physical check-up: _____

Medications (Prescription and Over-the-counter)

Allergies to medications? Yes No

If yes, which medications? _____

List the names of **current** 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	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol (elevated)	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Digestive	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Muscle/Bone	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Psychological	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Sinus	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Unusual Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
If not now, have you ever used tobacco in the past?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>

Is there a family history of any of the following?

	Relationship
Blindness	<input type="checkbox"/> _____
Corneal Problems	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> _____
Glaucoma	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/> _____
Lazy Eye	<input type="checkbox"/> _____
Macular Degeneration	<input type="checkbox"/> _____
Retinal Problems	<input type="checkbox"/> _____

What is the major purpose of this visit?

Date of your last eye exam: _____

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

- | | |
|--|--|
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Crossed Eye/
Eye Turn | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Floaters/Spots |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Grittiness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Itchiness |
| <input type="checkbox"/> Lazy Eye | <input type="checkbox"/> Macular
Degeneration |
| <input type="checkbox"/> Sunlight Sensitivity | <input type="checkbox"/> Trouble seeing at night |
| <input type="checkbox"/> Uncomfortable
Glasses | <input type="checkbox"/> Watery Eyes |
| <input type="checkbox"/> Other eye disorders _____ | |

Have you ever had any accidents, injuries or surgeries (i.e. Lasik, Cataract, etc.) to your eyes or head?

If yes, please list _____

Do you currently wear glasses? Yes No

Do you currently wear contact lenses? Yes No

If yes, are you satisfied with the vision and comfort of your contact lenses? Yes No

If no, are you interested in trying contact lenses? Yes No

Have you ever experienced any of the following?

- Feeling as though others mumble
- Difficulty hearing in background noise
- Difficulty following conversations in a restaurant
- Frequently asking others to repeat themselves

Are you interested in a hearing screening? Yes No

Do you currently wear hearing aids? Yes No

If yes, are you satisfied with them? Yes No

Are you interested in custom fit headphones or hearing protection (i.e. sleep or swim plugs)? Yes No