Maple Valley Vision Clinic

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 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.

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	☐	☐
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 Loss/Gain	☐	☐
Do you use tobacco?	☐	☐
If not now, have you ever used tobacco in the past?	☐	☐
Are you currently pregnant?	☐	☐

Is there a family history of any of the following?

		Relationship
Blindness	☐	________________
Corneal Problems	☐	________________
Diabetes	☐	________________
Glaucoma	☐	________________
Heart Disease	☐	________________
Lazy Eye	☐	________________
Macular Degeneration	☐	________________
Retinal Problems	☐	________________

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?

☐ Blurry Vision	☐ Burning
☐ Crossed Eye/ Eye Turn	☐ Double Vision
☐ Flashes of Light	☐ Floaters/Spots
☐ Glaucoma	☐ Grittiness
☐ Headaches	☐ Itchiness
☐ Lazy Eye	☐ Macular Degeneration
☐ Sunlight Sensitivity	☐ Trouble seeing at night
☐ Uncomfortable Glasses	☐ Watery Eyes

☐ 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