PATIENT INFORMATION

Name ____
Last First Middle

Address ____

City ______________________________________ State ________________ Zip ___________________

Home Phone (______) __________________ Date of Birth _____________ Age _______ Marital Status ___________

Cell Phone (______) ____________________ Social Security # __________________________ ☐ Male ☐ Female

Work Phone (______) __________________ E-mail Address ____

Employer ______________________________ Occupation ______________________________________

List your hobbies or activities that require special visual needs: ____

In case of Emergency contact:____________________ Phone_________________ Relationship _________

HOW WERE YOU REFERRED TO THIS OFFICE? (Check One)

☐ My Eye Doctor ☐ Primary Care Physician ☐ Internet/Advertisement ☐ Relative/Friend _____________ ☐ Other__________

Who is your Optometrist___________________________ Phone______________ City_______________

Who is your Primary Care Physician_______________________________ Phone____________________

Has your Eye Doctor ever discussed Laser Vision Correction with you? ☐ Yes ☐ No

DILATION ACKNOWLEDGMENT

I understand that dilating drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I am certain the effect of the medicine has worn off. The effect of the drops may last an hour or longer.

Signed ____ Date _______________

MEDICAL/VISION INSURANCE INFORMATION (Attach copy of Cards)

Medical Insurance Company: __________________________ Name of Policy Holder: _________________________

Policy Holder Date of Birth: __________________ Sex: _________ Relationship to Policy Holder: ___________________

Insurance ID #: ____________________________________ Group #: ________________________________

I understand I am financially responsible to the physician for the charges incurred unless prior arrangements have been made.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

TO MY INSURANCE CARRIER(S)

I authorize the release of any medical information necessary to process my insurance claim(s). I authorize and request payment of medical benefits directly to COASTAL VISION MEDICAL GROUP. I agree that this authorization *will* cover all medical services rendered until such authorization is revoked by me. I agree that a photocopy of this form may be used in lieu of the original.

Signed (Patient or Representative) ____ Date ____________________

Signed (Insured party other than patient) ____________________________________ Date ____________________

PAYMENT POLICY

Basic Policy:
Payment for service is due in full at the time service is provided in our office.

For Patients with Insurance:
We will bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Co-payments and deductibles are due at the time of service. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier has not paid or why it has paid less than participated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full by you.

I hereby attest that I am an eligible member of a contracted health plan as noted on page 1. I agree, that should it be determined that I am ineligible or services denied to me under the health plan noted, that I will be responsible for payment to: **COASTAL VISION MEDICAL GROUP**

Non-covered services:
Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

I acknowledge that I am responsible for all charges not covered by my insurance. I am responsible for Co-Insurance, Co-Pays and/or Deductibles required by my insurance. If **COASTAL VISION MEDICAL GROUP** is not contracted with my insurance, I understand I am responsible for the exam fee and all diagnostic testing and/or procedures performed. Additional non-covered items may be recommended by the surgeon. These items are considered elective and I am financially responsible. By signing below I am acknowledging my financial responsibility for services rendered.

Assignments of Insurance Benefits:
I hereby assign all medical benefits, to which I am entitled, private insurance, to Coastal Vision Medical Group, Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Have you met your deductible for the calendar year?
□ Yes □ No □ Not sure

I have read, understood, and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

Patient Name (Print): ____________________________________ Date of Birth: ________________

Patient/Guardian Signature: _____________________________________Date: _______________

Medical History Questionnaire

Name: ______________________________ Date of Birth: _____________ Date: _______________

Referring Doctor: _____________________ City:_________ Date of Last Eye Exam: ____________

Chief Complaint (CC): ____

____

History of Present Illness (HPI): ____

____

Current Eye Difficulties

Do you **currently** have any problems in the following areas? If yes please provide the information:

	Yes	**No**	**Which Eye?** (Right, Left, Both)	**Severity** (Mild, Moderate, Severe)
Blurred Vision				
Fluctuating Vision				
Distorted Vision (Halos/Floaters)				
Glare or Light Sensitivity				
Loss of Side Vision				
Double Vision (Horizontal or Vertical)				
Dryness				
Mucous Discharge				
Redness				
Sandy or Gritty Feeling				
Itching				
Burning				
Foreign Body Sensation				
Excess Tearing or Watering				
Eye Pain or Soreness				
Infection of Eye or Lid				
Tired Eyes				
Crossed Eyes or Lazy Eye				
Drooping Eyelid				

Do you drive? ❑ Yes ❑ No

Do you have visual difficulty when driving? ❑ Yes ❑ No

Do you have problems with night vision? ❑ Yes ❑ No

Have you ever tried to wear contact lenses? ❑ Yes ❑ No

If yes, how long have you worn contact lenses? ______________________

Do you currently wear glasses? ❑ Yes ❑ No

If yes, how long have you had the current prescription? ________________

General Medical History

	Yes	No	Details
General/ Constitutional (Fever, Weight Loss, etc.)			
Ears, Nose, Throat (Stuffy Nose, Earache, Cough, Dry Mouth, etc.)			
Cardiovascular (High blood pressure, Racing Pulse, etc.)			
Respiratory (Congestion, Wheezing, etc.)			
Gastrointestinal (Upset Stomach, Diarrhea, Constipation, etc.)			
Genital, Kidney Bladder (Painful Urination, Frequent Urination, Impotence, etc.)			
Muscles, Bones, Joints (Joint Pain, Stiffness, Swelling, Cramps, etc.)			
Skin (Pimples, Warts, Growths, Rashes, etc.)			
Neurological (Numbness, Headache, etc.)			
Psychiatric (Anxiety, Depression, Insomnia, etc.)			
Endocrine (Diabetes, Hypothyroid, etc.)			
Blood/Lymph (Cholesterolemia, Anemia, etc.)			
Allergic/Immunologic (Sneezing, Swelling, Redness, Itching, Hives, etc.)			

List all major illnesses (Glaucoma, Diabetes, High blood pressure, Heart Attack, etc.) or injuries (Concussion,etc.): ____

____

List any surgeries you have had (Cataract, Tonsillectomy, Appendectomy) and year: _______________

____

Have you ever had a blood transfusion? ❑ Yes ❑ No

Family History

	Yes	No	Relationship **M**= Mother **F**= Father **B**= Brother **S**=Sister **GM**= Grandmother **GF**= Grandfather
Arthritis			
Blindness			
Cancer			
Diabetes			
Glaucoma			
Heart Disease or High Blood Pressure			
Kidney Disease			
Lupus			
Stroke			
Thyroid Disease			
Other			

EHR Patient Data Collection Form

Date:_______________________

Patient Name: __________________________________ **Patient date of Birth:** ______________________

Race: ❑ White ❑ Latino ❑ Black or African American ❑ Asian ❑ Other Race ❑Decline to state	
Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Decline to state	
Preferred Language: ❑ English ❑ Spanish ❑ Vietnamese ❑ Chinese ❑ Other________ ❑ Decline to state	
Allergies to any Medications: ❑ None	
List of Current Medications (Prescription and over the counter): ❑ None	
Do you smoke?: ❑ Never Smoked ❑ Former Smoker ❑ Current every day smoker ❑ Current some day smoker ❑ ½ pack/day ❑ 1 pack/day ❑ 1+ pack/day	
Do you drink alcohol? ❑ Yes ❑ No ❑ Occasional ❑ 1 per day ❑ 2-3 per day ❑ 4+ per day	

Patient Pharmacy

Name: ____

Address/Cross Streets: ____

City: ______________________________ Phone Number: ___________________________

Patient Signature: ___________________________________

Revised 5/12/17 am

NOTICE OF PRIVACY PRACTICE

HIPAA (Health Insurance Portability and Accountability Act.) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign as acknowledging receipt of this brochure.

Print Name: ___________________________________ Date: _________________________

Signature: ____

How may we contact you and still provide the privacy and security you require as we protect your health and personal information.

Please check all that apply:

_______ Telephone and/or message to your answering machine

_______ Telephone and/or message to another person

(Please name: ______________________ Number: _________________________)

______ Mail or email: ____

_______ Contact you at work. (Please give phone number ____________________________)

_______ Designated caregiver, legal guardian or relative.

(Please name: _______________________ Number: ________________________)