COASTAL VISION
Medical Group Inc.

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 _____

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REFRACTIVE SURGERY PATIENT QUESTIONNAIRE

This information is strictly confidential. The answers will help determine if you are a suitable candidate. Certain health problems may indicate potential problems with healing. Please elaborate on all "yes" answers.

MEDICAL HISTORY:

1. Are you allergic to any medications? ❑ Yes ❑ No
   If yes, please list: _____
2. Have you ever taken or are currently taking Imitrex, Accutane or Cordarone? ❑ Yes ❑ No
   If yes, please circle above: _____
3. Do you take any medications on a regular basis, including birth control? ❑ Yes ❑ No
   If yes, please list: _____
4. Are you planning on pregnancy within the next year? Are you nursing? ❑ Yes ❑ No
5. Do you have a pacemaker? ❑ Yes ❑ No
6. Do you have any history of:

❑ Asthma / Eczema ❑ Heart Problems ❑ Diabetes
❑ Autoimmune Disease (Crohn's Disease, Lupus, Rheumatoid Arthritis, Etc.) ❑ Hepatitis
❑ High Blood Pressure ❑ HIV/ AIDS ❑ Rosacea ❑ Other: _____

EYE HISTORY:

1. How old were you when you first started wearing glasses? _____

2.

Any eye disorders	❑ Yes ❑ No	Retinal tear or detachment	❑ Yes ❑ No
Glaucoma (High eye pressure)	❑ Yes ❑ No	Cataract	❑ Yes ❑ No
Dry eye syndrome	❑ Yes ❑ No	Recurrent corneal erosion	❑ Yes ❑ No
Amblyopia ("lazy eye")	❑ Yes ❑ No	Keratoconus	❑ Yes ❑ No
Any eye injury	❑ Yes ❑ No	Any eye dystrophy or degeneration	❑ Yes ❑ No
Eye surgery	❑ Yes ❑ No	Any herpes infection in the eye	❑ Yes ❑ No
ALK/RK/LASIK/PRK Surgery	❑ Yes ❑ No	Other	❑ Yes ❑ No
Any infection in the eye	❑ Yes ❑ No		

If **YES** to any of the above, please explain: _____

CONTACT LENS HISTORY:

1. In what year did you first started wearing contact lenses? _____ What type? _____
2. What kind do you wear now? _____ How many hours a day _____
3. When did you last wear your contacts? _____
4. Any history of contact lens related eye infections? _____ Corneal ulcers? _____
5. Please check the type of contact lenses:

❑ Soft Daily Wear ❑ Soft Extended Wear ❑ Hard Contacts
❑ Soft Toric Lenses ❑ Disposable Contacts ❑ Rigid Gas Permeable

REASONS FOR WANTING REFRACTIVE SURGERY: (Check all that are applicable)

❑ **Job requirement** ❑ **Can't wear contact lenses** ❑ **Recreational activity (swimming, skiing, etc.)**
❑ **Cosmetic (I hate my glasses)** ❑ **Improved functional ability** ❑ **Simply Fed Up**
❑ **Reduce dependence on glasses/contacts** ❑ **Other**

1. **What concerns do you have about having laser vision correction?** _____
2. **When would you be interested in having laser vision correction if you are considered a candidate?** _____

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PRE-OPERATIVE SELF-EVALUATION
(WITH CORRECTION)

Please rate the following for each eye:

	RIGHT EYE				LEFT EYE			
	Absent	Mild	Moderate	Severe	Absent	Mild	Moderate	Severe
a. Light Sensitivity	❑	❑	❑	❑	❑	❑	❑	❑
b. Headaches	❑	❑	❑	❑	❑	❑	❑	❑
c. Pain	❑	❑	❑	❑	❑	❑	❑	❑
d. Redness	❑	❑	❑	❑	❑	❑	❑	❑
e. Dryness	❑	❑	❑	❑	❑	❑	❑	❑
f. Burning	❑	❑	❑	❑	❑	❑	❑	❑
g. Gritty Feeling	❑	❑	❑	❑	❑	❑	❑	❑
h. Glare	❑	❑	❑	❑	❑	❑	❑	❑
i. Halos	❑	❑	❑	❑	❑	❑	❑	❑
j. Blurry Vision	❑	❑	❑	❑	❑	❑	❑	❑
k. Ghost Images	❑	❑	❑	❑	❑	❑	❑	❑
l. Fluctuation of Vision	❑	❑	❑	❑	❑	❑	❑	❑
m. Difficulties with night driving	❑	❑	❑	❑	❑	❑	❑	❑

Other problems: _____

Comments: _____

Patient Pharmacy

Name: _____

Address/Cross Streets: _____

City: _____ Phone Number: _____

PATIENT SIGNATURE: _____ 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: _____

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: _____)