COASTAL PLAINS EYE CARE

NEW PATIENT PAPERWORK

Date: _____

Last Name: _____ **First Name:** _____ **MI:** _____

Suffix: _____ **Preferred Name:** _____ **Date of Birth:** _____

Sex: ☐ M ☐ F **Race:** _____ **Marital Status:** ☐ Single ☐ Married ☐ Other **SSN:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **Email:** _____

Employer: _____ **Occupation:** _____

Primary Care Doctor: _____

Emergency Contact: _____ **Phone Number:** _____

Who do you authorize to discuss your health or pick up your prescriptions/glasses/contact lenses?

_____ Relationship: _____

How did you hear of us?

☐ Drove by ☐ Google ☐ Social media ☐ Newspaper ☐ Friends/family ☐ Insurance ☐ Doctor referral

VISION CARE PLAN ☐ Eyemed ☐ Other/None (will be self-pay for vision/routine services)

Eyemed Member ID (if known): _____ Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child

PRIMARY MEDICAL INSURANCE Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child

Insurance: _____ Group #_____ Policy #_____

Policy Holder: _____ Policy Holder DOB: _____

SECONDARY MEDICAL INSURANCE Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child

Insurance: _____ Group #_____ Policy #_____

Policy Holder: _____ Policy Holder DOB: _____

Reason for today's visit: _____

Do you wear glasses and/or contact lenses? ☐ None ☐ Prescription glasses ☐ Contacts ☐ OTC readers

What do you use your glasses for? ☐ Full time ☐ Distance only ☐ Reading only ☐ Computer

How old are your glasses? _____ **When was your last eye exam?** _____

What brand of contacts do you wear? _____

What is your contact lens prescription? Right: _____ Left: _____

Have YOU ever been diagnosed with any of the following EYE conditions or diseases?

☐ **Negative/None**	☐ Diabetic retinopathy	☐ Keratoconus	☐ Retinal detachment
☐ Amblyopia (lazy eye)	☐ Dry eye	☐ Macular degeneration	☐ Strabismus (eye turn)
☐ Blindness	☐ Glaucoma (or suspect)	☐ Nystagmus	☐ Other:
☐ Cataracts	☐ Inflammatory disorders	☐ Retinal holes or tears	_____

Have you ever had any eye injuries, eye surgeries, eye injections, or other eye procedures? ☐ Yes ☐ No

If yes, please describe: _____

Are you currently experiencing any of the following symptoms or conditions? Please CIRCLE.

General	None	Fatigue Fever Weight loss/gain Fibromyalgia
Ear/Nose/Throat	None	Chronic Cough Dry Mouth Runny Nose Congestion Sinus
Cardiovascular	None	Heart disease High cholesterol High blood pressure Stroke Sleep apnea
Respiratory	None	Asthma Bronchitis Emphysema COPD
Genitourinary	None	Kidney Disease Prostate Problems STD
Musculoskeletal	None	Arthritis Joint Pain
Gastrointestinal	None	Crohn's Disease Irritable Bowel Syndrome Reflux
Skin	None	Eczema Itching Rosacea Dry
Neurological	None	Headache Migraines Multiple Sclerosis Numbness Seizures
Psychiatric	None	ADHD Anxiety Depression
Endocrine	None	Type 1 Diabetes Type 2 Diabetes Hyperthyroid Hypothyroid
Blood/lymphatic	None	Anemia Bleeding Disorders Leukemia HIV
Allergic/immune	None	Seasonal allergies Rheumatoid arthritis Lupus Sjogren's syndrome
Other	None	Pregnant Nursing Cancer _____

If you are DIABETIC or PRE-DIABETIC, what type? ☐ Borderline ☐ Type 1 diabetes ☐ Type 2 diabetes

Year diagnosed: _____ **Fasting blood sugar:** _____ taken _____ **Last A1c:** _____% taken _____

Have you ever had any other surgeries or hospitalizations? If yes, please describe:

_____

What medications do you take? ☐ I have provided a medication list (skip this section and give list to office staff)

_____

_____

Allergies: _____ **Preferred Pharmacy:** _____

Do you smoke? ☐ No – never smoker ☐ No – former smoker ☐ Yes – some day smoker ☐ Yes – every day smoker

If yes, what type? ☐ Cigarettes ☐ Cigars ☐ Smokeless tobacco **Do you drink alcohol?** ☐ Yes ☐ No

Does anyone in your IMMEDIATE FAMILY have the following EYE or MEDICAL conditions? ☐ NONE

☐ Glaucoma ☐ Retinal detachment ☐ Cataracts ☐ Crossed/lazy eye ☐ Macular degeneration ☐ Blindness

☐ Diabetes ☐ High blood pressure ☐ High cholesterol ☐ Thyroid condition ☐ Heart condition ☐ Cancer

Dilation Informed Consent

The health of your eyes is our priority at Coastal Plains Eye Care. It is important to have a yearly dilated eye exam to evaluate the health of your eyes in order to detect sight threatening conditions and diseases. Dilation also helps to determine a more accurate prescription for children.

Dilation is safe with minimal side effects. Side effects of dilation include light sensitivity and blurred near vision. These side effects can last for 4-6 hours at most. We recommend wearing sunglasses to drive home. Dilation shades will be provided at the end of your visit if needed.

____ I consent to dilation.

____ I do not consent to dilation and I understand the risks associated with not having a dilated eye examination.

Financial Policies and Assignment of Benefits

All payments are due at time of service. For patients with insurance, this includes the collection of all co-pays, deductibles, and co-insurances, if applicable. We will do our best to notify you ahead of time of your approximate copays and other fees but the exact amount may vary depending on services provided. These additional services may be necessary in order to provide you with the highest quality of care.

As a courtesy to our patients, we will file your medical insurance claim after each visit. You will be required to pay in full any amount that your insurance company has not paid. It is your responsibility to resolve any dispute over coverage or eligibility.

If a balance remains after your insurance carrier has paid its portion, we will send you a bill that will be due to us within 14 days of receipt. In the event where your insurance carrier pays a greater portion than expected, we will reimburse you the difference through a refund check or a credit on your account, whichever you prefer.

Vision plans such as EyeMed cover a routine eye exam and provide a discount towards the purchase of glasses or contact lenses. Vision plans do not cover medical eye care conditions, services, or treatments. Medical insurance applies to any situation where a medical problem affects the eyes (diabetes, cataracts, glaucoma, etc.) In the event that the conditions causing your symptoms are not refractive in nature, or if such conditions require additional counseling, testing or treatment, or put you at risk for vision loss, then your exam is no longer considered routine. If you are a diabetic, your visit with us will be processed through your medical insurance.

If we are not in network with your medical insurance or vision plan, we can provide you, upon request, with an itemized receipt so that you may file a claim with your insurance company for reimbursement. The amount of reimbursement will depend on your individual insurance or vision plan.

I hereby authorize Coastal Plains Eye Care to: (1) release any necessary information to insurance carriers regarding my illness and treatment; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature or digital signature to be used in processing claims. This order will remain in effect until revoked by me in writing. I have requested medical services from Coastal Plains Eye Care on behalf of myself and/or dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full upon presentation of a statement. A photocopy or digital copy of this assignment is considered as valid as the original.

_____ _____

Signature of Patient or Parent/Guardian Date

_____ _____

Patient Name (printed) Relationship to Patient

HIPAA Privacy Policy

Coastal Plains Eye Care will maintain the privacy of your health information and personal data. Your information will only be released upon your authorization. The law permits us to disclose your information for treatment, payment, and regular health care operations. A detailed privacy statement can be provided upon request. Federal Law requires that you be made aware of your privacy rights regarding your personal medical information.

_____	_____
Signature of Patient or Parent/Guardian	Date
_____	_____
Patient Name (printed)	Relationship to Patient

Professional Refraction Service and Fee

Refraction is the process by which the prescription of the eye is determined through the use of lenses. It is a necessary test in order to determine an accurate glasses prescription. Refraction is a professional service and has an associated fee if it is performed within the context of your exam.

Refraction is considered a non-covered service by most medical insurances, including Medicare. There are select insurances that will cover a refraction in the context of a routine eye exam. We will do our best to make you aware of such coverage, if applicable.

At Coastal Plains Eye Care, the fee for refraction is **$55**. **This fee will always be collected on the date of service if refraction is performed during the course of your visit.**

By signing below, you are acknowledging the above terms and **agree to pay the fee for refraction as outlined above.**

_____	_____
Signature of Patient or Parent/Guardian	Date
_____	_____
Patient Name (printed)	Relationship to Patient