

Date: \_\_\_\_\_



NEW PATIENT PAPERWORK

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Suffix: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Sex:  M  F Race: \_\_\_\_\_ Marital Status:  Single  Married  Other SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  Same as mailing address

If mailing address is different, where do you prefer mail to be sent?

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

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?**

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Negative/None        | <input type="checkbox"/> Diabetic retinopathy   | <input type="checkbox"/> Keratoconus            | <input type="checkbox"/> Retinal detachment    |
| <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Dry eye                | <input type="checkbox"/> Macular degeneration   | <input type="checkbox"/> Strabismus (eye turn) |
| <input type="checkbox"/> Blindness            | <input type="checkbox"/> Glaucoma (or suspect)  | <input type="checkbox"/> Nystagmus              | <input type="checkbox"/> Other: _____          |
| <input type="checkbox"/> Cataracts            | <input type="checkbox"/> Inflammatory disorders | <input type="checkbox"/> 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.**

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

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, I am acknowledging the above terms and **agree to pay the fee for refraction as outlined above.** I understand that I will receive a paper copy of my glasses prescription at the end of my visit if a prescription is finalized.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Name (printed)

\_\_\_\_\_  
Relationship to Patient