Coastal Eye Associates Medical History Form

Today's Date ___/___/_____ **DOB** ___/___/_____

Patient Name _____ □ **Male** □ **Female** **Age** _____

Mailing Address _____ **City/State** _____ **Zip** _____

Primary Phone _____ Home/Cell/Work **Secondary Phone** _____ Home/Cell/Work

Email Address _____ **OK to text in the future?** □ **Yes** □ **No**

Occupation _____ **Employer** _____

Referred By _____ **Hobbies** _____

Insurance information

Medical Insurance Company _____ **Relationship to Insured**_____

Member #_____ **Group #** _____ **Insured's name** _____

Vision Insurance □ **VSP** □ **EyeMed*** **Insured's SSN XXX-XX-**_____ **Insured's DOB** ___/___/_____

*Some EyeMed discount plans are limited to a certain selection of frames to use your insurance benefit.

Please note: Co-payments are due in full when services are rendered. Patient is responsible for payment of all services not covered by insurance. We will gladly submit claims to your insurance company if you provide the proper insurance information. We do not guarantee that your insurance will process payment for services.

Patient History

Reason for today's visit_____

Do you experience any of the following? (please check all that apply):

□ Blurred Vision □ Loss of Vision □ Double Vision □ Halos □ Eye Pain □ Other_____

□ Floaters/Spots □ Flashes □ Eye Strain □ Dry Eyes □ Red Eye

Last Eye exam ___/___/_____ **Doctor Name/Office** _____

Any history of injuries/surgeries to your eyes? _____

Do you currently wear glasses? □ **Y** □ **N** If yes, how old is your current pair? _____

Do you currently wear contact lenses? □ **Y** □ **N** If yes, how old is your current pair? _____

Type of contact lenses: □ **Rigid** □ **Soft** □ **Overnight/Extended** **Brand:**_____

Primary Care Physician _____ **Last Medical Exam** ___/___/_____

List all medications currently taken (including prescription, over the counter, and eye drops; may attach list)

_____

_____

Do you have any allergies to medications? □ **Yes** □ **No** _____

Name of Pharmacy _____

Are you currently pregnant and/or nursing? (if applicable) □ **Yes** □ **No**

Social History (please check all that apply): □ Current Smoker □ Former Smoker □ Never a Smoker

□ Alcohol Use; If yes, how much _____ □ Recreational Drug Use _____

Medical/Family History: Please check if you or a family member has been diagnosed with any of the following:

Disease/Condition	Self	Family Member	Disease/Condition	Self	Family Member
Glaucoma	□	_____	Diabetes	□	_____
Macular Degeneration	□	_____	Heart Disease	□	_____
Cataracts	□	_____	High Blood Pressure	□	_____
Amblyopia (Lazy Eye)	□	_____	High Cholesterol	□	_____
Retinal Detachment	□	_____	Tuberculosis	□	_____
Retinal Disease	□	_____	Other_____	□	_____

Review of Systems: Please check any condition you have NOW or have EVER had:

Cardiovascular
□ Hypertension
□ Arrhythmia
□ Heart Attack
□ Stroke

Constitutional
□ Fever
□ Weight change
□ Fatigue

Ear, Nose, Throat
□ Chronic Sinus
□ Hearing Aid(s)
□ Allergies

Endocrine
□ Type 1 Diabetes
□ Type 2 Diabetes
□ Hypothyroid
□ Hyperthyroid
□ Pituitary

Gastrointestinal
□ Colitis
□ Chron's
□ Ulcers

Genitourinary
□ Prostate
□ Kidney Disease
□ Bladder Disease

Hematologic
□ Anemia
□ Bleeding Disorder

Integumentary
□ Rosacea
□ Psoriasis

Infectious Disease
□ Hepatitis
□ HIV
□ Lyme Disease

Lymphatic
□ Leukemia/Lymphoma

Musculoskeletal
□ RA/ JRA
□ Lupus

Neurological
□ Headaches
□ MS
□ Tumor
□ Seizure

Psychiatric
□ ADD/ADHD
□ Alzheimers/Dementia
□ Anxiety/Depression

Respiratory
□ Asthma
□ COPD
□ Emphysema
□ Sleep Apnea
□ Sarcoidosis

List other diagnoses:_____

The above information is accurate to the best of my knowledge. I acknowledge that I have reviewed the Coastal Eye Associate's, PC notice of Privacy Practice.
Patient Signature: _____ Date ___/___/_____

Contact Lens Evaluation Fee
All contact lens patients will be assessed a contact lens evaluation fee of $50 annually to evaluate the health of the eyes in relation to the contact lenses. This is separate from the initial contact lens fitting fee ($100 and up) and the fee for being refit into a different lens ($60). The fee is due the *day of* the eye exam. Please understand that contact lens services are not included in your annual comprehensive eye exam. Your eye exam includes a prescription for eye glasses (refraction) and a full ocular health assessment. By law, contact lenses need to be evaluated annually and properly fit in order for your eye health and vision to be maintained. Most insurance companies do not cover this additional service. All contact lens prescriptions expire in 1 year.
I have read and understand the Contact Lens Evaluation Agreement:
Patient Signature: _____ Date ___/___/_____

No Show Policy effective 5/18/2020:
Many patients are waiting to be seen by our doctors at this time. When patients miss an appointment without providing proper notice, another patient is prevented from receiving care. All missed appointments and appointments which are not cancelled with 24 hours' notice (without a compelling reason) will be charged a $25.00 No Show Fee. This fee will be billed to the patient and is NOT covered by insurance. Thank you for your understanding.
By signing below, you acknowledge that you have received this notice and understand this policy.
Patient Signature: _____ Date ___/___/_____

Covid 19 Screening:
If you have a fever or are experiencing any symptoms related to COVID-19, we ask that you do not come to our office at this time. Symptoms include cough, shortness of breath, or difficulty breathing. This list is not all inclusive. Please consult your primary care physician with any concerns.