COASTAL EYE INSTITUTE

Patient Information Form

Chart #

NAME **First**	**Middle**	**Last**	Today's Date

Cell Phone _____ May we text you? (circle one) YES NO	Patient Social Security #
Home Phone	Patient Birth Date / / — Age
Work Phone	Circle one MALE FEMALE
Email Address: _____ May we email you? (circle one) YES NO	Occupation _____ How did you hear about us? _____
Local Mailing Address — Apt/Lot#	Emergency Contact
City — State — Zip	Phone
Out of Town / Other Address — Apt/Lot#	Relationship to Patient
City — State — Zip	Spouse Name

PRIMARY Insurance Company	
Policy Holder's Name	Policy Holder's Date of Birth / /
ID/Policy# Group#	Policy Holder's Social Security #
Relationship of patient to Policy Holder	Policy Holder's Work Phone
SECONDARY Insurance Company	
Policy Holder's Name	Policy Holder's Date of Birth / /
ID/Policy# Group#	Policy Holder's Social Security #
Relationship of patient to Policy Holder	Policy Holder's Work Phone

COASTAL EYE INSTITUTE

TREATMENT CONSENT, PATIENT RESPONSIBILITIES & INFORMATION RELEASE AUTHORIZATION

I give permission to Coastal Eye Institute to provide medical treatment for me/my child.

I allow Coastal Eye Institute to file for insurance benefits to pay for the care received. Coastal Eye Institute may send medical information to my/my child's insurance company and their subsidiaries.

Assignment of benefits will be made from my insurance companies to Coastal Eye Institute.

I must pay for my/my child's share of costs including deductibles, copayments, refraction fee and any non-covered services.

I must pay the entire cost of services if active insurance coverage is not in place or if the insurance company does not pay.

I understand that payment is due at the time services are rendered.

NOTICE OF PRIVACY PRACTICES: I have received a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand Coastal Eye Institute may change this notice at any time. I may obtain a current copy of the privacy notice by contacting Coastal Eye Institute or by visiting their website at CoastalEye.com.

I understand that Coastal Eye Institute will leave phone messages regarding test results, appointment times and other information on my home and cell phone. If I disagree, I will notify Coastal Eye Institute.

I understand and agree to all of the above:

Patient/Parent/Legal Guardian Signature_____ Date: ____/____/_____

If the patient is a minor (under the age of 18) or not legally responsible, please state:

Responsible Party: (Print Name) _____

Relationship to Patient: _____

Responsible Party's Date of Birth: ____/_____/_____

Address of responsible Party:

_____

_____

City_____ State_____ Zip _____

COASTAL EYE INSTITUTE

MEDICAL HISTORY & REVIEW OF SYSTEMS

PLEASE PRINT

Name _____ Birth Date ____/____/____ Today's Date ____/____/____

Who referred you to us? _____ Family Physician _____ Marital Status _____

Do you drink alcohol? yes no rarely *(PLEASE CIRCLE)* Do you smoke? yes no *(PLEASE CIRCLE)* Occupation _____

Are you allergic to latex, penicillin, sulfa or any other medications? yes no *If yes, please list:*

_____

_____

_____

_____

_____

Please list all current medications that you take:

_____

_____

_____

_____

_____

_____

Has any family member had:

Glaucoma? yes no _____ (list relatives)

Diabetes? yes no _____ (list relatives)

Corneal Transplant? yes no _____ (list relatives)

Retinal Detachment? yes no _____ (list relatives)

Macular Degeneration? yes no _____ (list relatives)

Other Eye Diseases? yes no _____ (list relatives)

Have you had surgery or hospitalizations ***not*** involving the eyes? yes no

If yes, please describe: _____

_____

_____

_____

DO YOU HAVE A HISTORY OF THE FOLLOWING MEDICAL PROBLEMS?

Circle Y or N		If yes, please describe
Y N	Retinal Detachment	
Y N	Glaucoma	
Y N	Arthritis / Lupus	
Y N	Cancer	
Y N	Diabetes	
Y N	Heart Attack	
Y N	Heart Disease	
Y N	High Blood Pressure	
Y N	Asthma/Emphysema	
Y N	Kidney Disease/Stones	
Y N	Stroke	
Y N	HIV/AIDS	
Y N	Bleeding Problems	
Y N	Other Illness	

DO YOU CURRENTLY HAVE PROBLEMS WITH ANY OF THE FOLLOWING?

Circle Y or N		If yes, please describe
Y N	Ears/nose/throat: i.e. dry mouth	
Y N	Heart: i.e. low blood pressure, heart failure or slow pulse	
Y N	Lungs: i.e. cough, history of TB, sarcoid or lung cancer	
Y N	General: i.e. fever or weight loss	
Y N	Psychiatric: i.e. depression	
Y N	Urinary: i.e. impotence or frequent urination	
Y N	Neurologic: i.e. migraines or memory problems	
Y N	Digestive: i.e. history of polyps, colon cancer or bloody stools	
Y N	Muscles/joints: i.e. joint swelling, prednisone or steroid use	
Y N	Blood/lymph: i.e. anemia or bleeding problems	
Y N	Urinary: i.e. urination pain, sexually transmitted disease, syphilis	

History of eye problems (including surgery or laser treatment on your eyes)? yes no *(If yes, please list all below with dates)*

Right Eye _____

_____

Left Eye _____

_____