EMERALD COAST
EYE CARE
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Patient Information
(MUST BE COMPLETED BEFORE BEING SEEN BY THE DOCTOR)

Today's Date _______________

Dr. / Mr. / Mrs. / Ms. Last Name ________________________________ First Name __________________________________ MI_____

Date of Birth ___________________ SSN ______________________ Sex: M or F [ ] Single [ ] Married [ ] Divorced [ ] Widowed

Mailing Address:

Street ____ Apt/Suite/Unit _______ City ____________________ ST____ ZIP__________

Home #____________________ Work #____________________ Cell #_____________________ Other #______________________

Email ____

Please rank (1-4) the best method of contacting you: [ ] Text cell phone [ ] Call Cell Phone [ ] Call Home Phone [ ] E-Mail

How did you hear about our office? ____

Employer: ____ Occupation: ____

Insurance Information
(MUST BE COMPLETED BEFORE BEING SEEN BY THE DOCTOR)

Vision Insurance ______________________________________ID: _____________________________________ Group# ___________

Subscriber Name ______________________________________ SSN#___________________ D.O.B. _____________________ [ ] self

Medical Insurance ____________________________________ID: _____________________________________ Group# ___________

Subscriber Name ______________________________________ SSN#___________________ D.O.B. _____________________ [ ] self

Secondary Insurance ___________________________________ID: ___________________________________ Group# ___________

Subscriber Name ______________________________________ SSN#___________________ D.O.B. _____________________ [ ] self

If we are filing medical insurance for your exam, there is a $40 refraction fee in addition to your medical co-pay.

How are you planning on settling your account today: [ ] Cash [ ] Credit Card [ ] Check

Please INITIAL next to the following statements to confirm that you understand and are in agreement with

_______ I understand that **VISION INSURANCE** covers a **WELL vision exam ONLY**. If there is a medical condition or complaint that requires any additional treatment, testing, and/or follow-up, Emerald Coast Eye Care will be required to bill my medical insurance (medical insurance deductibles and co-pays will apply). I have read and agree to comply with Emerald Coast Eye Care's billing policy.

_______ I understand that Emerald Coast Eye Care will only bill insurance that is **PROVIDED TO THE FRONT DESK** at the time of service. Any insurance information given after the date of service will not be retroactively billed.

_______ If my insurance company has not reimbursed Emerald Coast Eye Care in full within 90 days, I accept responsibility for payment unless otherwise noted.

I have read and agree to comply with Emerald Coast Eye Care's billing policy. I also certify that the information given is true and I accept responsibility for payment unless otherwise noted.

Signature ____ **Date** ___________________________________

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HIPAA

Please initial:

______ I acknowledge that Emerald Coast Eye Care has informed me they are compliant with HIPAA and has offered me a copy of their Notice of Privacy Practice and I can view a copy of their Notice of Privacy Practice at any time.

Medical Release Information

I ______________________________, give authorization for Emerald Coast Eye Care to discuss my medical and billing information with the following people.

Name ____ Relationship __________________________

Name ____ Relationship __________________________

Dilation Consent

The Florida Board of Optometry requires a comprehensive eye exam include a dilated fundus exam. This is done by placing drops in your eyes that make the pupils larger. The purpose of enlarging the pupils is to enhance the detection of any ocular diseases such as cataracts, glaucoma, retinal disease, malignant growth and retinal detachment; **all of which can lead to vision loss**. Some systemic conditions such as diabetes and hypertension can cause changes in the health of the eye and can be detected by dilation. ***Certain ocular and systemic conditions WILL require a dilated fundus exam; Children under the age of 18 will require a dilated fundus exam at their first visit at our practice.***

Please initial one:

______ I understand the above and consent to ***have dilation done today.***

______ I understand the above and accept the risk by ***declining dilation at this time.***

Digital Retinal Imaging

Our office has the latest in ocular diagnostic technology in 3D imaging. This allows instant viewing of the retina, optic nerve and other structures of your eye in great detail. The doctor will review the images with you and will store the image digitally for future comparison. Dr. Patterson is excited to offer this service to our patients and highly recommends a retinal imaging as part of your eye exam.

Please initial one:

______ Yes, please perform the digital retinal imaging as recommended. **I understand there is a $39.00 fee for this service, and it is NOT covered by insurance.**

______ No, I do not wish to have the optional imaging performed.

Patient Name ____ **Date of Birth** _______________________

Eye Health: Are you experiencing any of the following? No Yes

(PLEASE CIRCLE ALL THAT ARE APPLICABLE)

Blurred Vision	Double Vision	Headaches w/phone or computer
Burning	Eyestrain	Itching
Cataracts	Flashes of Light	Light Sensitivity
Dry Eyes	Floaters	Redness
Discharge	Glare	Watery

Last eye exam: Date: ______________________ **By whom**: ______________________________________

Have you had any eye surgery? No Yes

Type: ____________________________ **When**: ____________________________ **By whom**: ___________________________

Primary Care Doctor: ____

Preferred Pharmacy: ____

Are you currently taking any medications? No Yes

Current Medications: (Please include Rx, Eye Drops, Over the Counter Meds, Vitamins, and Birth Control)

____

____

____

____

Drug Allergies: No Yes **Please List:**

____

____

Any family history of the following conditions?

PLEASE CIRCLE: M - Mother F - Father B - Brother S - Sister GP – Grandparent

Glaucoma: M F B S GP	**Cancer**: M F B S GP
Macular Degeneration: M F B S GP	**Diabetes**: M F B S GP
Cataracts: M F B S GP	**High Cholesterol**: M F B S GP
Retinal Detachment: M F B S GP	**High Blood Pressure**: M F B S GP
Color Blindness: M F B S GP	**Thyroid Disease**: M F B S GP
No Family History **Unknown: Adopted**	**Autoimmune Disorder**: M F B S GP

Patient Name ____ **Date of Birth** ____________________

Patient Information: PLEASE CIRCLE where applicable

Are you currently pregnant? No Yes	**Race:** White Black/African American Asian
Are you currently nursing? No Yes	Native American Other: ________________
Smoking: Never Former Current: # _________ per day	**Ethnicity:** Hispanic/Latino Non-Hispanic/Latino
Alcohol: No Yes: #__________ per week	**Preferred Language:** _______________________

Are you currently experiencing or being treated for any of the conditions below?
PLEASE CIRCLE

Environmental Allergies	Asthma	Rosacea
Runny Nose	Chronic Bronchitis	Psoriasis
Cancer	COPD	Chronic Headaches
Type: ___________________________	Kidney Disease	Migraines
High Blood Pressure	Osteoarthritis	Seizures
Last B.P. Reading: ________________	Fibromyalgia	Parkinson's Disease
Vascular Disease	Ankylosing Spondylitis	Multiple Sclerosis
Stroke/TIA	Eczema	Alzheimer's Disease
Depression	Anemia	Other:
Anxiety	High Cholesterol	
Thyroid Disease	Rheumatoid Arthritis	
Non-Insulin dep. Diabetes	HIV	
Insulin dep. Diabetes	AIDS	
Diabetic for how long: ___________	HSV	
Last A1C: ________________________	Gastric Ulcer	
Last Blood Sugar: ________________	Lupus	

Are you having any problems with your current glasses or contacts? No Yes

If yes, please explain: ____

Do you currently wear contacts? No Yes

Brand: ___________________________ **Right eye**: ________________________ **Left eye**: ________________________

How often are you throwing away your used contacts? ____

Do you sleep in your contacts? No Yes

Patient Name ____ **Date of Birth** _____________________