Date:_____

COASTAL
VISION CENTER

Coastal Vision Center Proudly Serving the Southeast Since 1948

Section I: Patient information

Patients Name:_____
(Last, First, Middle)

Phone Number: Home: _____ Cell: _____

Email Address: _____

Mailing Address: _____

City: _____ State:_____ Zip:_____

Date of Birth: ___/___/___ Male( ) Female ( ) Single ( ) Married ( ) Divorced ( )

Social Security Number: _____

SECTION II: ***The following section will be applicable to the patient or the Parent or guardian for patients under the age of 18.***

Occupation: _____

Employer: _____

Employment Address: _____

City: _____ State: _____ Zip: _____

Business Phone: _____

SECTION III:

Who can we thank for referring you here? _____

Name of Referring Doctor:_____

Family Doctor Name: _____Phone Number: _____

Optometrist (Vision Doctor): _____Phone Number:_____

Emergency Contact:_____Phone Number:_____

SECTION IV: Insurance

Primary Insurance: _____ Policy Number: _____

Subscriber: _____ DOB: _____

Secondary Insurance: _____Policy Number: _____

Subscriber: _____ DOB: _____

COASTAL
VISION CENTER

PHOTO CONSENT FORM

I hereby give Coastal Vision Center I, and any and all employees and/or agents of Coastal Vision Center, the right and permission to use and/or publish photographs of me for art and promotional purposes including but not limited to, advertising, publicity, commercial or display of use. Also authorize my photos to be posted on social media, such as Facebook, Twitter, and the office's website page.

Release of Claims I hereby release and discharge Coastal Vision Center and all persons functioning under his/her permissions or authority from any legal or equitable claims including but not limited to the following: blurring of the image(s), alteration, distortion or use in composite form, libel, invasion of privacy or any claims based on the production or in the process of recording or publishing the materials.

Initial the following:
_____Yes, you may use my photos.
_____No, please do not use my photos.

_____ Name of Patient or Parent/Guardian (Please Print)
_____ Signature of Patient or Parent/Guardian
_____ Date

Assignment of Insurance Benefits

I, _____, do hereby authorize Coastal Vision Center, to acquire form and/or release on to my healthcare team and/or my insurance company(s), any information required for the purpose of healthcare management and.or processing all the medical claims on my behalf. I understand filing insurance is a courtesy and that upon acceptance of services from Coastal Vision Center. I assume Responsibility for any deductible, co-pays, or other balance not covered by my insurance carrier. I authorize Coastal Vision Center to submit claims to my insurance company on my behalf, and my insurance company to pay benefits directly to Coastal Vision Center. Should and insurance payment be made directly to the insured for monies due on this account, I agree to immediately pay over the funds to Coastal Vision Center. I will be informed of my insurance coverage and estimated out-of-pocket expenses at the time of Service.

We require 24 hour notice of cancellations to allow us to serve other patients. There is a $25.00 no show fee that will be posted to your account. There is a $10.00 billing fee for non-payment on the day services are rendered.

****** Returned checks will be subject to bank fees******

Refraction/Eye glass Prescription is $40.00

Patient/Guardian: Print Name:_____
Patient/Guardian Signature:_____ Date:_____

COASTAL
VISION CENTER

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law. The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ○YES ○NO
May we leave a message on your answering machine at home or on your cell phone ○YES ○NO
May we discuss your medical condition with any member of your family ○YES ○NO
If YES, please name the members allowed:

_____

_____

This consent was signed by: _____ (PRINT NAME PLEASE)
Signature: _____ Date: _____
Witness: _____ Date: _____

COASTAL VISION CENTER

Patient Name:_____Date: _____

MEDICAL INFORMATION SHEET

Past Medical History:

1. Do you have?

- ❑ Liver Disease
- ❑ Heart Disease
- ❑ Kidney Disease
- ❑ Lung Disease
- ❑ Thyroid Disease
- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Arthritis
- ❑ Other_____

2. Past Eye Surgeries or Laser Surgery

Cataract Surgery Date: _____

Glaucoma Surgery Date: _____

Retina Surgery Date: _____

3. Eye Diseases list any you have? _____

4. Drug Allergies: _____

5. Medications: Drug Name/Dose/Strength How you take it (for example, once a day, twice a day, etc)

_____

6. Family History of Eye Diseases and relationship (father/mother/sister/brother,etc):

Glaucoma _____ Blindness_____

Cataracts _____ Retinal _____

Other_____

7. Review of Systems: Do you have? (circle all that apply)

SKIN: itching, rash, ulcer, tumors (growths), other ☐Yes☐No

LYMPH NODES: swelling, tenderness, other ☐Yes☐No

BONES, JOINTS, MUSCLES: muscle pain/cramps, joint pain, swelling,other ☐Yes☐No

ENDOCRINE: (eg. Thyroid) fatigue, confusion, fainting, nervousness, hot/cold intolerance/hair loss, other ☐Yes☐No

ALLERGY/IMMUNOLOGY: recurrent infections, hayfever, hives, food allergy, drug sensitivity, other ☐Yes☐No

HEAD: headaches, dizziness, vertigo, other ☐Yes☐No

EARS: hearing loss, ringing, infections, other Yes No NOSE: bleeding, loss of smell, congestion, sinus problems, other ☐Yes☐No

THROAT: dry mouth, loss of taste, difficulty swallowing, hoarseness, other ☐Yes☐No

NECK: pain, swelling, stiffness, other ☐Yes☐No

BREASTS: tenderness, swelling, lumps, discharge, other ☐Yes☐No

BLOOD: bruise easily, prolonged bleeding, skin hemorrhages, blood loss, other ☐Yes☐No

RESPIRATORY: wheezing, cough(productive/blood), difficulty breathing, asthma, Other ☐Yes☐No

CARDIOVASCULAR (heart/blood vessels): chest pain, swelling of extremities, shortness of breath, exercise intolerance, etc ☐Yes☐No

GASTROINTESTINAL (stomach/intestines): nausea, vomiting, change in bowel habits, constipation, diarrhea, pain/cramps, bleeding, other ☐Yes☐No

GENITOURINARY (kidney/bladder): frequency, burning, hesitancy, pain or bleeding on urination, infections, incontinence, impotence, etc ☐Yes☐No

NERVOUS SYSTEM: weakness in arms or legs, numbness or tingling, loss of consciousness, falls, difficulty walking, seizures, tremors, neuralgia, other ☐Yes☐No

PSYCHIATRIC: disorientation, mood swings, anxiety, depression, hallucinations, other ☐Yes☐No