Dear Valued Patient,

Thank you for choosing South Coast Eye Care Centers for your eye care needs. Attached are our practice registration forms. Please complete all forms. After completing the forms,you can print the forms and bring them into the office. You will also need to bring your insurance card and a photo ID. Many insurance companies do not cover eye examinations, you may want to discuss with your insurance company prior to yourappointment.

Please bring a list of any medications and eye drops that you are currently using, along with your eyeglasses or contact lenses. If you have your contact prescription, please bring that prescription also. (see Contact Lens Policy attached)

Dilation of your eyes will probably be required for the examination. Since the effect of this procedure can take 4 to 6 hours to wear off, it is best that you not plan on driving immediately after the appointment and that you arrange for other means of transportation to return home. Sorry for the inconvenience, but we do not validate parking.

Everyone at South Coast Eye Care Centers takes great pride in making your visit as successful and pleasant as possible. Our goal is to consistently provide you with the highest quality of care in a friendly, inviting environment.

Respectfully,

Tobi Foisy
Office Manager

SOUTH COAST EYE CARE CENTERS

A Comprehensive Ophthalmology Medical Group, Inc.

Confidential Patient Information
(Please complete BOTH sides)

PATIENT INFORMATION

Name _____
Last First Middle Initial

Social Security #_____ Date of Birth_____ Age_____ Sex_____ Marital Status _____

Home Address _____
Street City State Zip Code

Home Phone _____Email Address _____Driver's License #_____

Employer_____Occupation_____Work Phone_____

Nearest Relative (not living with you)_____Relationship_____ Phone Number_____

RESPONSIBLE PARTY

Name _____ Social Security # _____

Home Address _____
Street City State Zip Code

Phone Number _____

INSURANCE INFORMATION

Insurance Carrier_____

Circle One: HMO PPO POS MEDICARE WC OTHER: _____

Do you have a Vision Plan? VSP MES AVP OTHER: _____

Policy Holder's Name _____ Date of Birth_____ Social Security # _____

ID# _____ Group Number _____

Secondary Insurance Carrier_____

Policy Holder's Name _____ Date of Birth _____ Social Security # _____

ID# _____ Group Number _____

ASSIGNMENT OF BENEFITS

I hereby authorize South Coast Eye Centers to furnish any information needed by any insurance carrier to process any claims for services rendered to the above named patient by South Coast Eye Centers. I assign any benefits payable by insurance carriers for those services to South Coast Eye Centers. I agree to be responsible for any amount not covered by insurance or for the full amount if the above named patient does not have insurance.

Signature _____ Date _____

REFERRAL INFORMATION

How did you hear about us? _____

Primary Care Physician _____ Phone Number _____

MINOR CHILD

I hereby certify that I am legally responsible for the above names patient, and I authorize South Coast Eye Centers to examine and treat this patient.

Signature _____

MEDICAL HISTORY QUESTIONNAIRE

List any **medications** you currently take (Rx and over-the-counter): _____

_____

_____

_____

Do you have **allergies** to any medication? ☐ YES ☐ NO

If YES, list the medications: _____

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or **injuries** (concussion, etc.): _____

_____

List any **surgeries** you have had (cataract, appendectomy): _____

Do you *currently* have any problems in the following areas? If YES, please provide additional information.

	YES	NO	Details
EYES (poor vision, eye pain, tearing, redness, etc.)	☐	☐	
GENERAL / CONSTITUTIONAL (fever, heat stroke, weight loss weight gain, unusually tired)	☐	☐	
EARS, NOSE, THROAT (hard of hearing, stuffy nose, earache, cough, dry mouth, etc.)	☐	☐	
CARDIOVASCULAR (high BP, racing pulse, etc.)	☐	☐	
RESPIRATORY (congestion, wheezing, short of breath, etc.)	☐	☐	
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)	☐	☐	
GENITAL, KIDNEY, BLADER (painful urination, frequent urination, impotence, yellow jaundice, etc.)	☐	☐	
FEMALES Are you pregnant? Nursing?	☐	☐	
MUSCLES, BONES, JOINTS (joint pain, stiffness, swelling, cramps, arthritis, etc.)	☐	☐	
SKIN (pimples, warts, growths, rash, etc.)	☐	☐	
NEUROLOGICAL (numbness, headache, seizures, paralysis, etc.)	☐	☐	
PSYCHIATRIC (anxiety, depression, insomnia)	☐	☐	
ENDOCRINE (diabetes, hypothyroid, etc.)	☐	☐	
BLOOD / LYMPH (bleeding, cholesterolemia, anemia, problems related to blood transfusion, etc.)	☐	☐	
ALLERGIC / IMMUNOLOGIC (sneezing, swelling, redness, itching, hives, lupus, etc.)	☐	☐	

FAMILY HISTORY (Mother, Father, Grandparent, Sibling)

Has any member of your family had these diseases (circle all that apply)? ☐ YES ☐ NO ☐ UNKNOWN

Blindness, Cataract, Glaucoma, Diabetes, Hypertension, Heart Disease, Stroke, Cancer, Thyroid Disease, Arthritis

Other heritable disease: _____

SOCIAL HISTORY

Does your vision limit any activities of daily living (driving, reading, sports, work, etc.)? YES ☐ NO ☐

Have you ever had a blood transfusion? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If YES, how much? _____

Do you smoke? ☐ YES ☐ NO If YES, how much? _____ How many years? _____

Primary Physician _____ *Endocrinologist* _____

SOUTH COAST EYE CARE CENTERS
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Lifestyle Questionnaire

Name: _____ Chart #: _____ Date: _____

1. Does wearing glasses bother or frustrate you? ○ Yes ○ No ○ Somewhat

2. Are you interested in surgery to reduce your need for glasses? ○ Yes ○ No ○ Somewhat

3. Would it bother you to wear glasses for some tasks after surgery? ○ Yes ○ No ○ Somewhat

4. Do you do a lot of night driving? ○ Yes ○ No ○ Somewhat

5. Do you notice halos or glare around lights while driving at night? ○ Yes ○ No ○ Somewhat

6. Would halos or glare around lights at night bother you after surgery? ○ Yes ○ No ○ Somewhat

7. Do you use a computer on a daily basis? ○ Yes ○ No ○ Somewhat

8. Do you do a lot of close detail work? ○ Yes ○ No ○ Somewhat

9. Have you ever tries monovision contact lenses? ○ Yes ○ No ○ Somewhat

9a. If "yes", did/do you like? ○ Yes ○ No ○ Somewhat

10. Check only two (2) ranges you would most prefer to see without glasses:

☐ Far	☐ Intermediate	☐ Near	☐ Other
Driving	Computer	Newsprint	Night driving
Television	Cooking	Cell phone	Star gazing
Sightseeing	Makeup	Maps	Dim light far
Movies	Price tags	Sewing	Dim light near
Outdoors	Looking in a mirror	Prescription labels	Sharp-shooting

11. Would you like to have, without glasses, good distance vision during the day, and good near vision for reading in good light, even if you might see some halos or glare around lights at night?
○ Yes ○ No ○ Somewhat

12. How would you describe you personality? ○ Easy-going ○ Perfectionist ○ Between the two

13. Please initial one:

_____ ☐ I AM interested in surgery to help reduce my need for glasses. I understand insurance does NOT pay for this portion. Any additional cost related to reducing my need for glasses is "out-of-pocket."

_____ ☐ I AM NOT interested in surgery to help reduce my need for glasses. I understand after cataract surgery my glasses prescription will change and I will likely need glasses for most everything.

Please Sign Here _____

Refraction Service and Fee Agreement

A refraction is the process of determining if there is a need for corrective eyeglasses or contact lenses. It is an essential part of an eye examination and necessary to write a prescription for glasses and contact lenses, as well as determine certain types of eye diseases and problems.

Most medical insurance plans, including Medicare, do NOT cover routine refractions or routine eye examinations (when no medical eye problem is known or suspected). Medicare allows that we charge separately for this portion of the examination since it is not a covered service.

If you have a separate vision plan that covers routine or annual eye examinations and/or glasses, please let us know. Your vision plan may assist you with your eye care needs that are not covered by your medical plan.

Our office fee for the refraction is $50.00 and that fee is collected at the time of service, in addition to any co-payment your plan may require. hould your plan pay for the refraction, we will reimburse you accordingly.

If you have any questions regarding Medicare and insurance policies and procedures, please do not hesitate to ask. We will do our best to assist you.

Patient Acknowledgement

I have read the above information and understand that the refraction is a non-covered service. I accept full financial responsibility for the cost of this service and understand that payment is due at the time of service. I understand that any co-payment, coinsurance, or deductible I may have is separate from and not included in the refraction fee.

_____ _____

Patient Signature (Parent for Minor) **Date**

Contact Lens Policy

(Please review prior to your appointment)

Our goal is to provide you with the highest quality ophthalmic care and the most convenient service. In order to best serve you, contact lens prescribing and dispensing require careful attention. Complications may occur with appropriate lenses; however, a poorly fitting contact lens is much more likely to cause inflammation or infection resulting in permanent loss of vision. Therefore, for your safety, we routinely require the following examinations prior to prescribing contact lenses:

1. A complete eye examination – This is important to rule-out any contraindications to contact lens wear and to consider which lenses will most likely fit your needs.
2. A contact lens fitting appointment with one of our Certified Ophthalmic Technicians to identify an appropriate lens for trial wear.
3. A follow-up examination with the doctor to assess the contact lens fit afterwards – usually 1 -3 weeks later.

These precautions are necessary to reduce risk of vision-threatening complications due to contact lens wear. If you are currently wearing a particular brand of contact lens and would like a refill prescription at your complete eye examination, the doctor may provide your Contact Lens prescription if :

1. You have your contact lens information available. This requires the brand name, refractive prescription, and base curve which are almost always provided on the contact lens box.
2. You are able to wear your current lenses to the appointment so that the doctor may assess the fit.

A charge of $60.00 will be due at the time of service to update your prescription. You may not require a separate appointment if your contact lenses are fitting well.

We strongly recommend that you keep a pair of updated glasses for use in the event your contact lenses are either unavailable or problematic.

We look forward to becoming your most trusted resource in ophthalmic care.

Note: Please be advised that a $25.00 fee will be charged for failure to keep contact lens appointments without giving a 24 hour notice of cancellation.

08/14bm