

COASTAL EYE CENTER / Paul D. Pare', M.D.

Date: _____ Referred By: _____

Name: _____
Last First M.I.

Date of Birth: _____ Age: _____ SS # _____

Marital Status: _____ Spouse's Name _____

Race: (circle one)	Language: (circle one)	Ethnicity: (circle one)
American Indian or Alaskan Native	English	Hispanic origin
Asian or Pacific Islander	Spanish	Not of Hispanic origin
Black	Other _____	
White		

LOCAL Address: _____
Street Unit/Apt #

City State Zip Code

OTHER Address: _____
Street Unit/Apt #

City State Zip Code

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Employer: _____ Occupation: _____

Employer Address: _____
Street Suite

City State Zip Code

Emergency Contact Name: _____ Emergency Phone: _____

Name & Address of RESPONSIBLE PARTY (If other than patient)

Name: _____ Phone: _____

Address: _____

Street _____ Unit/Apt # _____

City _____ State _____ Zip Code _____

Insurance Information: _____
Primary Secondary

Please complete the information below if you are not the primary policy holder on your insurance.

Policy Holder's Name: _____ DOB: _____ Soc. Sec. #: _____

I authorize any holder of medical or other information about me to be released to the Social Security Administration, Health Care Financing Administration or its intermediaries or carriers, or any other insurance carrier, or to the billing agent of this supplier, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I hereby acknowledge responsibility for payment in full, in the case, that my primary and/or secondary insurance company fails to pay any or all of my claims. In the event that I am found or known to be without insurance, I acknowledge that I will be responsible for payment in full at time of services rendered.

I permit the use of this signature for the entire length of my association with Coastal Eye Center, Paul D. Pare', M.D., or until such time as all benefits due to Coastal Eye Center are paid in full. By signing below I verify that all the information I provide is accurate and valid.

Please be aware, a charge will be made for broken appointments, unless 24 hours notice is given.

Patient Signature

Parent or Guardian Signature

Coastal Eye Center, P.A.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that a copy of Coastal Eye Center, P.A.'s
Notice of Privacy Practices is available to me.

Name (Please Print)

X

Signature

Date

Please list the names of any persons you wish for information to be released to.

Name & Relationship to Patient

Name & Relationship to Patient

Name & Relationship to Patient

Please circle your contact preference regarding confirming appointments, test results, etc.

Circle yes or no if messages can be left at that contact preference.

Home phone

Cell phone

Work phone

E-mail

Y / N

Y / N

Y / N

Y / N

COASTAL EYE CENTER COMPLETE MEDICAL HISTORY

Name _____ Date _____

Sex _____ Weight _____ Date of Birth _____ Local Physician _____

DO YOU WEAR GLASSES FOR: Distance Y N Reading Y N Bifocals Y N Trifocals Y N Progressives Y N
Computer or other special need (piano, organ, etc.) Y N

CURRENT CONTACT LENSES Y N Past Contact Lenses Y N Distance – Monovision – Bifocal (circle one)

PRIOR REFRACTIVE SURGERY (LASIK/OTHER) Y N - DESCRIBE _____

PLEASE CIRCLE ANY PROBLEMS YOU CURRENTLY HAVE:

Blurred Vision Halos/Glare Double Vision Dryness/Burning Mucous Discharge Itching
Excess Tearing/Watering Eye Pain Crossed Eyes/ Lazy Eyes Drooping Eyelid(s)

EYE HISTORY – Have you or any of your blood related family members had any of the following?

<u>SELF</u>		<u>FAMILY MEMBER</u>		<u>RELATION</u>
Cataracts	Y N	Cataracts	Y N	_____
Glaucoma	Y N	Glaucoma	Y N	_____
Diabetes	Y N	Diabetes	Y N	_____
Retinal Detachment	Y N	Retinal Detachment	Y N	_____
Macular Degeneration	Y N	Macular Degeneration	Y N	_____
Eye Surgery	Y N	Eye Surgery	Y N	_____
(describe _____)				

SOCIAL HISTORY

Current or Previous Occupation _____

Primary Language _____

Do you smoke? Y N Past Smoker Y N Amount and duration _____

Do you drink alcohol? Y N If yes, list amount per week _____

Do you drive? Y N Do you have trouble driving (glare, halos)? Y N do you wear dentures Y N

Do you live alone? Y N Do you live in a nursing home? Y N If yes, which one? _____

MEDICATIONS - prescription and non-prescription (or attach list)

<u>Drug name</u>	<u>Dose</u>	<u>Drug name</u>	<u>Dose</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES! - to medications, foods, or other

LIST ANY SURGERIES, HOSPITALIZATIONS, AND SERIOUS ILLNESSES OR ACCIDENTS

FAMILY HISTORY – mother, father, grandparent or sibling – list serious medical diseases affecting your family members:

PLEASE TURN OVER AND COMPLETE OTHER SIDE!

PAST MEDICAL HISTORY – Please indicate whether you have had any of the following medical problems.

CHEST LUNGS

Asthma/Wheezing Y N
Emphysema Y N
Shortness of Breath Y N
Other _____

EXTREMITIES

Arthritis Y N
Rheumatoid/Osteo
(circle one)
Osteoporosis Y N

GENITOURINARY

Kidney Stones Y N
Prostate Enlargement Y N
Other _____

Weight Loss Y N
Explain _____

HEART/CARDIOVASCULAR

Angina Syndrome Y N
Heart Attack Y N
Carotid Disease Y N
Congestive Heart Failure Y N
Cardiac Arrhythmia Y N
Circulation Problems Y N
High Blood Pressure Y N
Pacemaker/Defibrillator Y N

ENDOCRINE

Diabetes Y N
Thyroid Disease Y N
Hyper/Hypo(circle one)
Graves/MG (circle one)
Other _____

CANCER (including skin)

Describe _____

Updated 7/11

NEUROLOGICAL

Previous Stroke or TIA Y N
Headache Y N
MS Y N
Seizures Y N
Bell's Palsy Y N R L
Dementia/Alzheimer's Y N
Parkinson's Y N

PSYCHIATRIC

Anxiety Y N
Depression Y N

COCHLEAR IMPLANTS Y N

HEMATOLOGIC

Bleeding Disorder Y N
High Cholesterol Y N
Blood Transfusion Y N

GASTROINTESTINAL

Hepatitis Y N
Ulcers, GERD Y N
Other _____

IMMUNOLOGIC

Immune Deficiency Y N
Sjogren's Y N
HIV/AIDS Y N
Other _____

SKIN

Shingles Y N
Melanoma Y N
Rosacea Y N
Herpes Simplex Y N

Date _____

Doctor Signature _____

Coastal Eye Center

PATIENT STATEMENT FOR NON-HMO PATIENTS

I certify that I am **NOT** a member of any Health Maintenance Organization (HMO). If I am enrolled in an HMO or fail to get proper authorization prior to treatment, I agree to **take full responsibility for the entire amount of any charges that I may incur.**

Signature of Patient or Authorized Party

Date

Witness

PATIENT STATEMENT FOR HMO PATIENTS

I certify that I **AM** a member of the Health Maintenance Organization (HMO) listed below. I am aware that it is my responsibility to make sure that I have proper authorization in order for services to be covered. **I will take full responsibility for any charges that are not covered due to lack of proper authorization or denial by my HMO for any reason.**

Name of HMO of which I am currently a member:

Signature of Patient or Authorized Party

Date

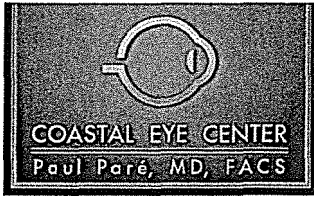
Witness

I certify that I **AM** enrolled in a Health Maintenance organization (HMO) which Coastal Eye Center may or may not have a participating provider agreement. I prefer to be seen **WITHOUT** waiting for the necessary authorization. **I take full responsibility for the entire amount of any charges I incur.**

Signature of Patient or Authorized Party

Date

Witness



304 SE Hospital Ave
Stuart FL 34994
Office 772-283-8444

Patient name-
Account #-

Billing and Insurance Policy

We look forward to treating your ophthalmic needs. To enable us to best treat you we would like to provide you with our billing and insurance policies as they relate to you. Please read and initial each paragraph.

We require you to have a refraction once a year. This is the test to determine whether you need a prescription for eyeglasses in order to obtain your best vision or if your current glasses need to be updated. This is a necessary part of a thorough eye exam and is not a covered service by insurance. There will be a \$40.00 charge which will be paid at the time of the visit. An eyeglass prescription will not be issued otherwise. If you are considering cataract surgery this test is essential to determine if surgery is necessary.

Initials: _____

Our policy requires you to present insurance cards (if applicable) at every visit. Every effort is made to verify insurance coverage before services can be rendered. Verification of insurance coverage is not a guarantee of payment by your insurance company. If we are unable to verify your coverage and benefits you may be required to pay in full upfront. However, if your insurance company does reimburse for services we will refund you for the amount overpaid. Please note that if your insurance requires an authorization to see a specialist, you will need to call your primary care physician at least 72 hours prior to each appointment. Our office cannot obtain authorization for you.

Initials: _____

As mandated by the federal government, all insurance companies including Medicare require that you, the patient, pay your co-pay and deductible as part of your contract with your insurance company. Failure to do so is violation of your contract and against the law. Because of this, we cannot waive co-pays and deductibles. We require you pay your co-pay/deductible/co-insurance at the time of each appointment.

Initials: _____

I also understand and acknowledge that I am personally responsible to pay in full for services that my health insurer will not cover due to non-payment of my health insurance premiums. Any returned checks will result in an additional \$30.00 fee.

Initials: _____

We will call to confirm your appointment at least 24 hours ahead of time. Failure to cancel your appointment 24 hours ahead of time or failure to show for your scheduled appointment will result in a \$25.00 charge that is not covered by your medical insurance.

Initials: _____

Thank you for your cooperation and understanding.

Signature of patient

Date

ATTENTION ALL PATIENTS

Effective January 1, 2011 we will be transmitting your prescriptions to the pharmacy via computer. Please make sure we have your current pharmacy information.

Thank You

Dr. Pare & Staff

Pharmacy Name: _____

Location/Address: _____

Pharmacy Phone Number: _____

Mail Order Pharmacy: _____

Patients Name/Signature: _____