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

Date: _____

How did you hear about us? Circle one

Website Advertisement

Friend _____

Doctor_____

Name: _____
Last First M.I.

Date of Birth: _____Age:_____ SS #_____

Marital Status: _____ Spouse's Name_____

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

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

Local Pharmacy Name: _____

Pharmacy Location: _____

Pharmacy Phone#: _____

Pharmacy mail order: _____

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, 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 hour notice is given.

_____ _____
Patient Signature **Parent or GuardianSignature**

COASTAL EYE CENTER
Paul Paré, MD, FACS

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 recommend you have a refraction (this is not the same as dilation) once a year. **This is the test to determine whether you need a prescription for eyeglasses in order to obtain your best vision, if your current glasses need to be updated or if you feel there has been a change in your vision**. This is a necessary part of a thorough eye exam and is not a covered service by any insurance. This is a **$50.00** 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. **By initialing you agree to a refraction test at today's visit.**

Initials: _____

Our policy requires you to present insurance cards (if different than what we have on file) 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.

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 if it applies. 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 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 48 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.

Initials: _____

Thank you for your cooperation and understanding.

_____ _____

Signature of patient Date

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.

_____

Patient Name (Please Print)

E-MAIL:_____

Primary Care Physician: _____

X_____

Patient Signature Date

Please list the names of any persons you wish information to be released to, **if they call us.**

_____

Name & Relationship to Patient

_____

Name & Relationship to Patient

_____

Name & Relationship to Patient

_____

***Emergency Contact**- Name & Relationship **Phone Number**

Circle yes or no if messages can be left for patient with these forms of contact.

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?

SELF		FAMILY MEMBER		RELATION
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_____
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?_____
Are you currently in rehab? Y N Are you currently enrolled in hospice? Y N

MEDICATIONS - prescription & non-prescription (or attach list) **If none please write none**

Drug name	Dose	Drug name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES! - medications, foods, or other (**Or write NONE**)

_____

LIST ANY SURGERIES, HOSPITALIZATIONS, AND SERIOUS ILLNESSES OR ACCIDENTS (OR WRITE NONE)

_____

FAMILY HISTORY – mother, father, grandparent or sibling – list serious medical diseases affecting your family members: **OR WRITE NONE**

_____

PLEASE TURN OVER AND COMPLETE OTHER SIDE!

PAST MEDICAL HISTORY – Please indicate whether you have had any of the following medical problems. **Circle Y for Yes or N for No**

CHEST LUNGS
Asthma/Wheezing Y N
Emphysema Y N
Shortness of Breath Y N
COPD Y N
Other_____

EXTREMETIES
Arthritis Y N
Rheumetoid/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 5/12

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_____