WELCOME TO COAST EYECARE, PLLC

Patient's name_____Birth date_____
Last First Middle Initial

Marital status_____If Child, Parent's name_____

Please circle preferred method of communication: mail / email / home phone / cell phone / work phone

Address_____City_____Zip Code_____

Home Phone_____Work_____Cell_____

Email_____Patient Social Security #_____

Occupation/Grade_____Place of Employment/School_____

Preferred Language(other than English)_____

Preventative Health Information: (Dept. of Health and Human Services Meaningful Use Questionnaire)

Height_____Weight_____ Blood Pressure(if known)_____Blood Sugar/A1c_____

Gender_____Race_____Ethnicity(Hispanic/Latino?) Yes or No

Smoking Status (please circle): Current / Former / Never

Primary care Doctor_____Date & Reason for last visit _____

Insurance Guarantor Information (please provide insurance cards):

Name_____Birth date_____Social Security #_____

Relationship to Patient_____Address(if different)_____

Please list all diagnosed eye health conditions or eye surgeries:

Please list all diagnosed health conditions:

Please list all medications and dosages you are taking or provide a copied list:

Please list any medication allergies and reaction caused by them:

OFFICE POLICY
PLEASE READ CAREFULLY

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS OR OTHER INSURANCE BE MADE EITHER TO ME OR ON MY BEHALF TO **JAMES B. BENIGNO, JR, O.D./COAST EYECARE, PLLC** FOR ANY SERVICES FURNISHED ME BY SAID DOCTOR. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT MYSELF, TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION OR THE ABOVE INSURANCE COMPANY AND ITS AGENTS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

PATIENT/GUARANTOR
SIGNATURE_____DATE_____

A QUOTE OF BENEFITS IS NOT A GUARANTEE OF PAYMENT. ALL BENEFITS ARE SUBJECT TO THE TERMS, CONDITIONS, LIMITATIONS, AND EXCLUSIONS UNDER THE MEMBER'S POLICY, INCLUDING THE PATIENT'S EFFECTIVE STATUS ON THE ACTUAL DATE OF SERVICE. **IT IS FIRST AND FOREMOST THE PATIENT/GUARANTOR'S RESPONSIBILITY (AND NOT OUR OFFICE ADMINISTRATION) TO UNDERSTAND ALL THE TERMS OF THEIR INSURANCE POLICY.**

PATIENT/GUARANTOR
SIGNATURE_____DATE_____

I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE POLICY. THE AMOUNT NOT COVERED BY MY INSURANCE POLICY MUST BE PAID WHEN SERVICES ARE RENDERED.

PATIENT/GUARANTOR
SIGNATURE_____DATE_____

CONTACT LENSES MUST BE PAID FOR IN ADVANCE BEFORE THEY CAN BE ORDERED.

FEES PAID FOR EYE EXAMINATIONS ARE NON-REFUNDABLE.

FEES PAID FOR CONTACT LENS FITTING AND EVALUATION ARE NON-REFUNDABLE.

PATIENT/GUARANTOR
SIGNATURE_____DATE_____