WELCOME TO OUR OFFICE

PLEASE COMPLETE THE FOLLOWING Date (mm/dd/yyyy):_____

PATIENT INFORMATION					
LAST NAME ☐ MR ☐ MRS ☐ MS ☐ DR	FIRST NAME	MIDDLE	DATE OF BIRTH		
HOME ADDRESS	CITY	STATE	ZIP CODE		
HOME PHONE	WORK PHONE	MOBILE PHONE	EMAIL ADDRESS		
PLEASE CHECK YOUR PREFERRED METHOD(S) OF CONTACT: ☐ HOME PHONE ☐ WORK PHONE ☐ MOBILE PHONE ☐ EMAIL					
EMPLOYER/SCHOOL	OCCUPATION/GRADE	HOBBIES/SPECIAL INTERESTS			

HOW DID YOU HEAR ABOUT OUR OFFICE	
☐ INSURANCE ☐ LOCATION ☐ INTERNET ☐ PHONE BOOK ☐ MAILING AD ☐ REFERRAL	WHOM MAY WE THANK FOR REFERRING YOU?

IF THE PATIENT IS UNDER 18 YEARS OF AGE		
NAME OF PARENT/GUARDIAN	HOME OR MOBILE NUMBER	RELATION TO PATIENT
EMERGENCY CONTACT		
NAME OF EMERGENCY CONTACT	HOME OR MOBILE NUMBER	RELATION TO PATIENT

MEDICAL INFORMATION			
PRIMARY CARE PHYSICIAN	DATE OF LAST PHYSICAL	LAST EYE DOCTOR	DATE OF LAST EYE EXAM
MEDICAL INSURANCE COVERAGE			
NAME OF MEDICAL INSURANCE	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTHDATE	RELATION TO PATIENT
VISION INSURANCE COVERAGE			
NAME OF VISION INSURANCE	POLICY HOLDER (EMPLOYEE)	POLICY HOLDER BIRTHDATE	RELATION TO PATIENT

CARE CREDIT & HEALTH SAVINGS ACCOUNTS (HSA)		
DO YOU HAVE **CARE CREDIT** TO ASSIST WITH YOUR HEALTH CARE COSTS?	☐ YES	☐ NO
WOULD YOU LIKE TO LEARN HOW **CARE CREDIT** CAN HELP WITH MEDICAL AND VISION EXPENSES?	☐ YES	☐ NO
DO YOU HAVE A **HEALTH SAVINGS ACCOUNT (HSA)**?	☐ YES	☐ NO

DIGITAL RETINAL IMAGING

Coastal Vision believes that using the best technology is crucial to maintaining good ocular health. We utilize Digital Retinal Imaging, which produces a high definition image of your retina, optic nerves, and other internal structures. These images give our doctors a valuable supplement to your comprehensive exam. The imaging also serves as a very important baseline, so every year your eyes can be compared to past images to monitor for even the smallest changes. Although not covered by insurance, our doctors request retinal photos every 12 months for every patient.

☐ Yes, I would like to have Digital Retinal Imaging performed today (additional fee of $39)

☐ No, contrary to our doctors' request, I am declining retinal photos

Patient/Guardian Signature _____ DATE _____

DO YOU CURRENTLY:

- ☐ Wear glasses? If so, how old are they: _____
- ☐ Wear polarized sunglasses? If so, how old are they: _____
- ☐ Wear contact lenses? If so, what brand: _____

ARE YOU INTERESTED TODAY IN:

- ☐ Purchasing new eyewear
- ☐ Trying contact lenses
- ☐ Learning about refractive surgery

YOUR VISUAL FUNCTION (Please check all that apply to you):

- ☐ Work on computers under fluorescent lighting
- ☐ Spend time doing outdoor activities
- ☐ Enjoy boating or other water sports
- ☐ Eyes are sensitive to sunlight
- ☐ Drive to/from work directly facing the sun
- ☐ Occupation involves possibility of eye injury
- ☐ Contact lenses get dry at least once a day
- ☐ Contact lenses are not as clear as desired
- ☐ Experience glare while driving at night
- ☐ Experience eye strain while using the computer
- ☐ Read books/study for longer than 2 hours a day
- ☐ Would like info on thinner/lighter lenses

HISTORY OF EYE SURGERY (Please check any that apply along which eye):

Cataract ☐ Right Eye ☐ Left Eye | LASIK/PRK Surgery ☐ Right Eye ☐ Left Eye | Other Eye Surgery: _____

Eye Muscle ☐ Right Eye ☐ Left Eye | Retinal Surgery ☐ Right Eye ☐ Left Eye

DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING

- ☐ Blurred vision
- ☐ Burning
- ☐ Double vision
- ☐ Drooping eyelid
- ☐ Dryness
- ☐ Excessive tearing
- ☐ Eye pain/soreness
- ☐ Flashes of light
- ☐ Floaters in vision
- ☐ Glare sensitivity
- ☐ Eye/eyelid infection
- ☐ Itching
- ☐ Sandy/gritty feeling
- ☐ Sudden vision loss
- ☐ Loss of side vision
- ☐ Other: _____

VISION/OCULAR HISTORY
(Please check any conditions that apply to YOU or BLOOD RELATIVES):

F = father M = mother B = brother S = sister GP = grandparent(s)

☐ NONE	YOU	FAMILY MEMBER
Amblyopia/lazy eye	☐	☐F ☐M ☐B ☐S ☐GP
Cataracts	☐	☐F ☐M ☐B ☐S ☐GP
Color blindness	☐	☐F ☐M ☐B ☐S ☐GP
Crossed/turned eyes	☐	☐F ☐M ☐B ☐S ☐GP
Diabetic retinopathy	☐	☐F ☐M ☐B ☐S ☐GP
Glaucoma	☐	☐F ☐M ☐B ☐S ☐GP
Herpes eye disease	☐	☐F ☐M ☐B ☐S ☐GP
Keratoconus	☐	☐F ☐M ☐B ☐S ☐GP
Macular degeneration	☐	☐F ☐M ☐B ☐S ☐GP
Retinal detachment	☐	☐F ☐M ☐B ☐S ☐GP
Traumatic eye injury	☐	☐F ☐M ☐B ☐S ☐GP
Other eye condition	☐	☐F ☐M ☐B ☐S ☐GP

SOCIAL HISTORY

Smoker? ☐ No ☐ Yes Amt: _____

Previous smoker? ☐ No ☐ Yes

Alcohol? ☐ No ☐ Yes Amt: _____

FEMALES:

Are you pregnant? ☐ No ☐ Yes

Are you nursing? ☐ No ☐ Yes

PLEASE LIST ALL CURRENT MEDICATIONS
(Please include over-the-counter medications and supplements)

☒ NONE

MEDICAL HISTORY
(Please check any conditions that apply to YOU or BLOOD RELATIVES):

F = father M = mother B = brother S = sister GP = grandparent(s)

☐ NONE	YOU	FAMILY MEMBER
Cancer	☐	☐F ☐M ☐B ☐S ☐GP
Fatigue	☐	☐F ☐M ☐B ☐S ☐GP
Nose, Sinus, Throat	☐	☐F ☐M ☐B ☐S ☐GP
Hearing Impairment/Loss	☐	☐F ☐M ☐B ☐S ☐GP
Neurologic, MS	☐	☐F ☐M ☐B ☐S ☐GP
Stroke/CVA	☐	☐F ☐M ☐B ☐S ☐GP
Autism Spectrum Disorder	☐	☐F ☐M ☐B ☐S ☐GP
Headache/migraine	☐	☐F ☐M ☐B ☐S ☐GP
Psych(anxiety, depression)	☐	☐F ☐M ☐B ☐S ☐GP
High Blood Pressure	☐	☐F ☐M ☐B ☐S ☐GP
Cardiovascular (heart, carotid)	☐	☐F ☐M ☐B ☐S ☐GP
Respiratory (asthma, emphysema)	☐	☐F ☐M ☐B ☐S ☐GP
Sleep Apnea	☐	☐F ☐M ☐B ☐S ☐GP
GI (Reflux, Crohn's, Colitis)	☐	☐F ☐M ☐B ☐S ☐GP
Genital/Urinary (Kidney, Prostate)	☐	☐F ☐M ☐B ☐S ☐GP
STD (Chlamydia/Herpes)	☐	☐F ☐M ☐B ☐S ☐GP
Arthritis	☐	☐F ☐M ☐B ☐S ☐GP
Ankylosing Spondylitis	☐	☐F ☐M ☐B ☐S ☐GP
Skin (acne, eczema)	☐	☐F ☐M ☐B ☐S ☐GP
Herpes Simplex/Cold Sores	☐	☐F ☐M ☐B ☐S ☐GP
Herpes Zoster/Shingles	☐	☐F ☐M ☐B ☐S ☐GP
Diabetes (Type 1/Type 2)	☐	☐F ☐M ☐B ☐S ☐GP
Thyroid Dysfunction	☐	☐F ☐M ☐B ☐S ☐GP
Blood disorder (Anemia)	☐	☐F ☐M ☐B ☐S ☐GP
High Cholesterol	☐	☐F ☐M ☐B ☐S ☐GP
Rheumatoid Arthritis	☐	☐F ☐M ☐B ☐S ☐GP
Lupus	☐	☐F ☐M ☐B ☐S ☐GP
Sjögren's Syndrome	☐	☐F ☐M ☐B ☐S ☐GP

PLEASE LIST ALL ALLERGIES
(Please include environmental allergies and drug allergies)

☒ NKDA ☒ NKA

Clear Form Print Form