COASTAL EYE GROUP, P.C.

Patient Name: _____ **Birthdate**:_____

Please update the following:

Consent to Call, Email, or Text

Consent to Call or Email indicates the patient is giving permission for the practice to use information provided as part of the check in process to email and call the patient. This includes: Entry of any telephone contact number constitutes written consent to receive any automated, prerecorded, and artificial voice telephone call initiated by the practice, or third parties, and more.

Consent to Text indicates whether the patient has agreed to receive automated text alerts from the practice on their mobile phone. Depending on the features the practice offers, text alerts may be about appointments, test results, and more.

By signing below, the patient is giving permission for the practice to use information provided as part of the check in process to email, call, or text the patient. Depending on the features the practice offers, calls, emails, or texts may be about appointments, test results, and may extend to third parties or more.

Home Phone_____ **Cell Phone** _____**Work phone** _____

Preferred methods of contact: Home#___Work#___Cell#___Text___

Circle One *- Yes or No - OK to leave message*

_____ _____

Patient Signature Required **Date**

****PLEASE UPDATE THE FOLLOWING:**

Patient Address: _____ **Patient Phone #:** _____

_____

_____

Primary Insurance: _____**Secondary Insurance:**_____

Patient Signature: _____ **Date:** _____

MEDICAL HISTORY QUESTIONNAIRE

Patient Name _____
Date of Birth _____ Date of **last eye exam** _____
List any **medications** you currently take (Rx and over-the-counter with dosages):
_____
_____
Do you have **allergies** to any medications? **YES NO**
If YES, list the medications with **reactions** _____
_____
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, stents,etc.)			
RESPIRATORY (congestion, wheezing, short of breath, use oxygen, etc.)			
GASTROINTESTINAL (stomach upset, diarrhea, constipation, hernia, ulcers, etc.)			
GENITAL, **KIDNEY**, **BLADDER** (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, stroke, 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**
List Mother (M), Father (F), Brother (B), Sister (S), Grandparent (GP)
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? _____
Have you ever smoked?..... **YES NO** If Yes, when did you stop? _____

Patient's Signature: _____ **Date** _____

Physician's Signature: _____ **Date** _____

NO SHOW POLICY

Coastal Eye Group schedules appointments so that each patient receives the appropriate time to be seen by our physicians. It is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, Coastal Eye Group sends reminder calls and text messages 2 days in advance of your appointment.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and to accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours notice.

If you do not cancel or reschedule your appointment with at least 24 hours notice, we may assess a $30.00 "NO SHOW" service charge to your account. This "NO SHOW" charge is not reimbursable by your insurance company. You will be billed directly for it.

I UNDERSTAND THE "NO SHOW" POLICY OF COASTAL EYE GROUP AND I UNDERSTAND THAT I MUST CANCEL OR RESCHEDULE ANY APPOINTMENT AT LEAST 24 HOURS IN ADVANCE IN ORDER TO AVOID A POTENTIAL NO SHOW CHARGE.

Date:_____

Patient Name(please print):_____

Patient Date of Birth:_____

Patient Signature:

_____

7/1/2022