WELCOME TO OUR OFFICE
STEPHANIE COATES, O.D.

PLEASE PRINT

Date_____ Birthdate_____ Age_____

Name_____Married____Single____Email_____

Address_____City_____Zip_____

Social Security Number_____Home Phone_____Cell_____
Occupation_____Email_____
Employer_____WorkPhone_____
Spouse's Employment_____Work Phone_____
Date of last eye examination_____Last Doctor_____

Are you experiencing any of the following eye problems? Burning____Itching____Tearing____Gritty sensation ____
Eye pain____Blurred vision ____Double vision ____Light sensitivity ____Flashes of lights ____Spots or Floaters ____Redness____
Headaches ____Eye fatigue _____Mucus discharge ____Halos ____Glare____
Other_____

Do you have any problems in the following areas? Skin____Eyes____Ears____Nose____Mouth____Throat____
Lungs____Heart/Blood vessels____Chest/Breast____Stomach/Intestines____Genital/Kidney/Bladder____Bones____
Joints____Muscles____Neurological____Lymph____Blood____Allergy/Immune____Psychiatric____

Do you have any of the following? Diabetes____ High blood pressure____ Heart disease____ Stroke____
Cancer____Asthma____HIV____Hepatitis____TB____Glaucoma____Cataracts____Macular degeneration____
Thyroid disease____Lupus____Kidney disease____Arthritis____Lazy eye____Retinal detachment____
Other_____
Is there any family history of any of the above conditions?_____
_____
Describe any eye injury_____
Have you ever had eye surgery?____Describe_____
Are you taking any medication? Please list. Include eye drops and over the counter medications_____
_____
_____
List any medications you are allergic to_____
Do you use any of the following? Tobacco____Alcohol____Any history of substance abuse____
Primary Care Physician_____Address_____

ROUTINE VISION PLAN_____**POLICY #**_____

MEDICAL INSURANCE_____**POLICY #**_____

Have you ever worn contact lenses?_____If yes which type_____
Do you currently wear contact lenses?_____Type_____Solutions_____
How long do you wear your contact lenses?_____Hours_____Days How often are they replaced?_____
Are you interested in learning more about contact lenses?_____ **Are you interested in new frames or lenses?**_____

Do you work on a computer?_____How many hours a day?_____
Do you have any problems seeing your screen or do you have any eye problems associated with the computer?_____
List hobbies, activities or sports_____

Who may we thank for referring you_____

I understand that payment is expected when services are rendered and it is my responsibility to pay for services and or products that may not be covered by my insurance. I authorize release of my records to my insurance company and to other doctors that are involved in my care and allow Dr. Coates or her agent to bill my insurance for payment.

Patient signature_____

Guardian_____

INFORMATION REGARDING DILATING EYE DROPS

Dilating eye drops are used to dilate or enlarge the pupils of the eye to allow Dr. Coates to get a better view of the inside of your eye. Looking into an undilated eye is like trying to take inventory of your room by looking through the keyhole instead of opening the door.

Dilating drops frequently blur near vision for a length of time, and causes sensitivity to light. It is not possible for your eye doctor to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself if possible. Our office will provide disposable sunglasses to make it easier and safer for you to drive after dilation. Please ask for them at the front desk.

Adverse reaction, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. Stephanie Coates and/or such assistants as may be designated by her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

_____ _____

Patient (or person authorized to sign for the patient) Date

_____ _____

Witness Date

FINANCIAL POLICY

Thank you for choosing our office and allowing us to provide your eye care. We are committed to providing you with the highest level of care. The following is a statement of our financial policy, which we require that you read and sign prior to any treatment.

- **Full payment is due at the time of service**
- **No refunds will be given on professional services**
- **No refunds will be given on glasses once the order is placed**
- **Prescription eyeglass remakes, for any reason, may or may not be covered under your vision plan at no additional charge.**
- **We accept Cash, Check, Visa, Master Card, Discover and Debit Cards**
- **Last minute cancellations or not showing for an appointments will result in a $30 charge to your account.**
- **There is $50.00 return check fee, for all checks returned**

Important information Regarding Insurance

You are required to pay your deductible and percentage that your insurance does not cover at each visit. We will be happy to submit a claim to your insurance company for you. We cannot bill your insurance unless you bring **all** your insurance cards, both vision and medical. Our office strives to provide high quality, dependable and ethical eye and vision care.

We see many patients with "vision plans" like VSP, VCP, Eyemed and Davis which cover a well vision exam and vision correction. <u>These are vision plans and only cover vision disorders correctable by glasses or contact lenses.</u> If you have a medical eye condition, we will need to bill your medical insurance since this does not fall under "wellcare". We will be happy to participate in most all medical plans. Unfortunately several in our state exclude optometrists.

Payment for services is the responsibility of the patient, or the patient's medical or vision insurance plan if we are contracted providers.

When acting in the capacity of a contracted provider, we reserve the right to judge which third party payer, wellcare or medical, is the most appropriate to submit a claim for payment.

VISON PLANS ONLY COVER VISION CONDITIONS AND MEDICAL PLANS COVER MEDICAL EYE CONDITIONS.

I HAVE READ THE FINANCIAL POLICY ABOVE. I UNDERSTAND AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY.

Signature of responsible party_____Date_____

HIPPA AUTHORIZATION & CONSENT FORM

This is to advise that I have read and understand Dunedin Eye Care's Notice of Privacy Act which is kept on the counter of the office and I certify that the below information is correct my Personal Medical Information (PMI). I also authorize payment be made directly to Dunedin Eye Care for all assigned claims.

PATIENT NAME: _____

DATE OF BIRTH: _____

RELEASE TO MY SELF ONLY _____ (Please ck)

RELEASE MY INFO TO: _____

_____

List names of whom you wish to know your PMI

DATE: _____

SIGNATURE: _____