Ocean Ophthalmology

Demographic Questionnaire:

Reason for visit:	
Referring Provider (who sent you?)	
Primary Care Physician Name:	**Phone Number:**

Full Name:		**Date of Birth:**	**Gender:**
Address:		**City/State:**	**Zip Code:**
Home Phone:	**Mobile Phone:**	**Marital Status:**	
Email Address:	**Social Security:**		
Emergency Contact Name:		**Relationship:**	**Phone:**
Primary Insurance:	**ID:**	**Group:**	
Secondary Insurance:	**ID:**	**Group:**	
Vision Plan:	**ID:**	**Group:**	

Medical History Questionnaire:

List all medications you currently take:
List all major illnesses and surgeries (glaucoma, diabetes, cataract surgery, etc.):
Do you have any allergies to medications? YES/NO (list):

Do you currently have any problems in the following areas?	**YES**	**NO**	**Details**
Eyes (poor vision, eye pain, tearing, halos, dryness, redness, floaters, etc.)			
General/Constitutional (fever, weight loss, tired, etc.)			

Ear, Nose, Throat (stuffy nose, ear ache, cough, dry mouth, etc.)			
Cardiovascular (high blood pressure, racing pulse, etc.)			
Respiratory (congestion, wheezing, short of breath, etc.)			
Gastrointestinal (stomach upset, diarrhea, constipation, ulcers, etc.)			
Genital, Kidney/Bladder (painful/frequent urination, impotence, etc.)			
Females: Are You Pregnant? Nursing?			
Muscles, Bones, Joints (Joint pain, stiffness, swelling, gout, etc.)			
Skin (warts, growths, rash, etc.)			
Neurological (numbness, headache, seizures, dizziness, etc.)			
Psychiatric (anxiety, depression, insomnia, etc.)			
Endocrine (diabetes, hypothyroid, etc.)			
Blood/Lymph (bleeding, bruising, anemia, high cholesterol, etc.)			

Family History / Social History:

Have you traveled outside of the country recently? When/where			
Has any member of your family (parents, siblings, grandparents) had the following? (Circle all that apply) BLINDNESS/CATARACT/GLAUCOMA/ MACULAR DEGENERATION/ DIABETES/ HYPERTENSION /HEART DISEASE/ STROKE/ ARTHRITIS/ CANCER			
Do you drink alcohol?	YES	NO	**How frequently?**
Have you had a blood transfusion?	YES	NO	
Do you smoke?	YES	NO	**How frequently? For how many years?**
Do you drive?	YES	**NO**	

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OUR POLICIES

(Please Read and Sign carefully if you have any questions do not hesitate to ask).

Insurance Benefits Authorization

I request that payment of authorized insurance benefits be made on my behalf to this office for any services furnished by the physician to me. I authorize any holder of medical information about me be released to any health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date: _____

Patient Insurance Responsibilities

I understand that I am responsible for payment of deductibles, coinsurance, and copayments as re quired by my insurance carriers.

Signature _____ Date: _____

HIPPA Privacy Notice

Our office has always supported and recognized our patients' right to expect that their records and other information about their care will be kept confidential. One of the provisions of the HIPAA privacy regulations is that all healthcare providers distribute a "Notice of Privacy Practices". All patients can receive this notice upon request or read the notice posted in the waiting room. Patients are not required to read this notice, but we are asking that you acknowledge that you have received access to th is notice in our waiting room.

Signature _____ Date: _____

Refractions

Ocean Ophthalmology

A **REFRACTION** test is usually given as part of a routine eye examination by an optometrist, It may also be called a vision test. This test tells your eye doctor exactly what prescription you need in your glasses or contact lenses.

DO YOU WISH TO HAVE A REFRACTION DONE ANOTHER DAY WITH OUR OPTOMETRIST? YES/NO

DO YOU WANT A CONTACT LENS FITTING? YES/NO

PLEASE NOTICE * Patients without **(VISION INSURANCE)** being seen with their medical insurance, interested in a refraction, as a courtesy we offer the refraction at a cost of $45.00 this service is not covered by your medical insurance with our optometrist who comes into the office once a month.

Signature _____ Date: _____

Cancellation/Missed Appointment Policy

Our goal at Ocean Ophthalmology Group is to provide you with convenient, accessible, high quality medical care. For us to assure convenience and accessibility to all our patients, it is important that patients arrive timely for all scheduled appointments or cancel the appointment **48 *hours*** in advance. This policy allows us to make better use of our available appointments for those patients in need of medical care. A "missed appointment" is an occurrence where someone does not show up for an appointment and does not cancel the appointment in advance of the scheduled date and time. If you do not show up for your appointment and you do not cancel the appointment **48 *hours*** in advance, you will be charged a ***$25.00*** cancellation fee. Each time you miss your appointment, you will be notified by telephone and you will be asked to re-schedule.

Signature _____ Date: _____