# Coastal Skin & Eye Institute

## New Patient Packet

Name:_____ Date of Birth:_____

Address:_____ City, State, Zip:_____

Home #:_____ Work #:_____

Mobile #:_____ Email:_____

Primary Care Physician: _____

Pharmacy Name & Address: _____

How did you hear about us?

- ☐ Facebook/Instagram
- ☐ Website
- ☐ Del Mar Times Ad
- ☐ Direct referral from MD
- ☐ Word of Mouth
- ☐ Other. Please specify _____

Please circle the best phone number for you. May we text you for:

___ Health and Appointment notifications

___ Discounts/Specials/Promos

Emergency Contact Name / Phone #:_____

Relationship to Emergency Contact:_____

I authorize Coastal Skin & Eye Institute, to submit a medical claim to my medical insurance carrier or its intermediaries for all covered services or products provided by the practice. I understand that I am responsible for any deductible, coinsurance, copayment or non-covered services. I understand that it is the policy of the practice to collect at the time of service. I understand that the practice is able to refer my account to collections if I do not make payment. I understand that it is my responsibility to update my insurance file whenever I change insurance carriers. I understand that failing to provide current information will make me immediately responsible for balances otherwise paid by my medical carrier. I understand that if I join an HMO, I will inform the practice prior to scheduling any case, such that the staff can identify my eligibility for care with this practice. I have completed the above information and certify that it is true and correct to the best of my knowledge. I will notify the office of any changes in my health status or the above information.

Signature of Patient or Legal Representative: _____

Date: _____

# Medical History

## Past Medical History (please circle all that apply):

| | | |
|---|---|---|
| Anxiety | Depression | Leukemia |
| Arthritis | Diabetes | Lung Cancer |
| Artificial Joints | End Stage Renal Disease | Lymphoma |
| Asthma | GERD (Acid Reflex) | Pacemaker |
| Atrial Fibrillation | Hearing Loss | Prostate Cancer |
| Benign Prostatic Hyperplasia | Hepatitis | Radiation Treatment |
| Bone Marrow Transplant | Hypertension | Seizures |
| Breast Cancer | HIV / AIDS | Stroke |
| Colon Cancer | Hypercholesterolemia | Valve Replacement |
| COPD (Emphysema) | Hyperthyroidism | |
| Coronary Artery Disease | Hypothyroidism | |

**Other:** _____

☐ **Auto Immune**: Check if applicable and specify: _____

☐ **None**

## Past Surgical History

_____

_____

## Skin Disease History (please circle all that apply):

| | | |
|---|---|---|
| Acne | Dry Skin | Poison Ivy |
| Actinic Keratoses | Eczema | Precancerous Moles |
| Asthma | Flaking or Itchy Scalp | Psoriasis |
| Basal Cell Skin Cancer | Hay Fever & Allergies | Squamous Cell Skin Cancer |
| Blistering Sunburns | Melanoma | |

☐ **None**

Do you wear sunscreen? Yes No
If yes, what SPF? _____ _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relatives? _____ _____

Any other family history? _____ _____

## Ocular History (please circle all that apply):

| | | |
|---|---|---|
| Amblyopia | Dry Eyes | RK |
| Cataracts (Right, Left) | Glaucoma (Right,Left) | |
| Corneal Dystrophy (Right, Left) | Lasik | |
| Diabetic Retinopathy (Right, Left) | Macular Degeneration | |
| Double Vision | PRK | |

Other:_____

## Medications and Supplements

| **Medication Name** | Mg/ Mcg |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| **Drug Allergies:** | |

**Family History**

| | Mother/ Father | Grandmother/Father | Sibling |
|---|---|---|---|
| Hypertension | | | |
| Diabetes | | | |
| Cataracts | | | |
| Lupus | | | |
| Arthritis | | | |
| Glaucoma | | | |
| Macular Degeneration | | | |
| Other Eye Diseases | | | |

**Cigarette Smoking No Yes Former**
Current everyday smoker No Yes
Number of packs per day_____
Date started Smoking_____
Date Quit_____

**Do you drink Alcohol? Yes No**
If yes, how many per week?_____

**Notice of privacy practices as required by the privacy regulation created because of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).**

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that I have the right to review a Notice of Information Practices that gives a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation, will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions that the organization has already taken action in reliance thereon.

The Privacy Rule gives the right to access an individual's health records to a personal representative of the individual. If you would like a representative to have access to your health records, please indicate so below.

Name of Representative: _____ Phone Number: _____

Relationship to Patient: _____

**Signature of Patient**: _____ Date: _____

**** Patient must sign here even if they do not wish to give access to any representatives.**

## Payment Policy

CSEI will send a medical claim to your insurance company based on the insurance information that you have provided to us. We will require you to provide our office with complete insurance or workman comp information including the name of the carrier/claim mailing address, the insured's person name, member/subscriber ID (which may be the SSN), group number, and employer information for each visit.

This is not a guarantee of any insurance benefit. All patients bear responsibility for their insurance benefits. If your insurance company does not pay your claim, you will be expected to pay the total balance owed.

All (including self-pay) patients have financial responsibility for all services that were rendered and our office accepts payment in the form of cash, check, and all major credit cards.

**Signature of Patient or Legal Representative**: _____

Date: _____