COASTAL SKIN & EYE INSTITUTE
REGISTRATION FORM

Email:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Dr. ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:			Home phone no.: ( )	
City	State:	ZIP Code:			Mobile phone no: ( )	
Occupation:	Employer:				Work number.: ( )	

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet search ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Notice: Pages are front AND back!

IN CASE OF EMERGENCY			
Name:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance and that is my responsibility to provide complete and correct insurance information. I also authorize [Name of Practice] or insurance company to release any information required to process my claims. *Patient/Guardian signature* *Date*			

If using a vision plan, please complete the following:

Name of vision insurance:		
Subscriber's name:	Group no:	Policy no:

Pharmacy information:

Name:	Ph no:	Address:

May we text you for:

▫ health and appointment notifications

▫ discounts/specials

Statement of Insurance Use and Authorization

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 can 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:_____

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 Reflux)	Pacemaker
Atrial Fibrillation	Hearing Loss	Prostate Cancer
Benign Prostate 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	

☐ Autoimmune conditions:_____

☐ Other: _____

☐ None

Past Surgical History: (please fill in)

Type of surgery:	Approximate date:

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

Amblyopia	Dry Eye	Glaucoma (Right, Left)
Cataract (Right, Left)	Blepharitis	RK
Corneal Dystrophy	Macular Degeneration	
Diabetic Retinopathy	Retinal Detachment (Right, Left)	
Double Vision	LASIK or PRK (Right, Left)	

☐ Other: _____

Family History: (please fill in)

	Mother/Father	Grandmother/Grandfather	Sibling
Hypertension			
Diabetes			
Cataracts			
Lupus			
Arthritis			
Glaucoma			
Macular degeneration			
Other eye diseases			

Medications and Supplements: (please fill in or attach separate list)

Medication name	Dosage

Drug Allergies: (please fill in)

Medication name	Reaction

Other History:

Cigarette Smoking: ▫Yes ▫No ▫Former

How many packs/day? _____

Started: _____ Quit: _____

Do you drink alcohol: ▫Yes ▫No

If yes, how many drinks per week? _____

COASTAL SKIN & EYE INSTITUTE
EYE REFRACTIONS AND MEDICAL INSURANCE

Payment for REFRACTIONS

One of the most important parts of an eye exam is checking a refraction. A refraction is the part of the exam by which we determine whether your vision can be helped in any way with a new glasses prescription. You may remember this test as “Which is better, 1 or 2?” We do not know if your glasses or contact prescription has changed unless we check it.

Checking a refraction is NOT a covered service by Medicare and most other insurance plans. Please see the CMS publication “Your Medicare Benefits” if you have any questions about this. These plans consider refraction a “vision” service not a “medical” service. Our office fee for refraction is $50, and unless your plan automatically covers the refraction charge, this fee is collected at the time of service in addition to any co-payment your plan may require.

If you have VISION INSURANCE in addition to medical insurance, we can use your vision insurance benefits to cover the refraction. You may combine the benefits of both insurance plans. Vision insurance rarely covers imaging/testing to diagnose eye disease or monitor its progress. If you require these advanced services, their charges will be applied to your medical insurance plan, and any deductibles or coinsurance requirements of your medical insurance plan will apply.

We have made an attempt to contact your carrier(s) prior to the arrival for your appointment to maximize your benefit coverage and to determine your financial responsibilities. Please understand that whatever we report to you is only an estimate. We are not your insurance carrier and can only discuss your coverage and benefits from the information they report to us.

Please select one option below:

___ I have read the above information and understand that the refraction is a non-covered service through medical insurance. I accept full financial responsibility for the cost of this service and understand it is due at time of service. I understand that any co-payment, coinsurance or deductible I may have are separate from and not included in the refraction fee.

___ I decline the refraction service today. I understand that without the refraction, Dr. Crosby or Dr. Varshney may not be able to fully assess the health and function of my eyes.

___ I have a separate “VISION INSURANCE” plan and want to use my VISION INSURANCE benefits for my refraction service today. I have provided the office with an up-to-date VISION INSURANCE card and understand that it is my responsibility to make sure my benefits are active.

Signature of Patient or Legal Representative:_____

Date: _____

COASTAL SKIN & EYE INSTITUTE
CONTACT LENS FITTING AND EVALUATION

Please read if you would like a new contact lens prescription.

Contact lenses are a medical device that are fitted to wear on top of the cornea. Before we can give you a new prescription, we are required to check the health of your eye and the contact lens fit. This is regardless of whether you are experiencing any change in vision.

All corneal evaluations for contact lenses will include 90 days of follow up care. After 90 days, a charge of $75 will be applied for any additional visits. Once finalized by the doctor, a contact lens prescription will be given with an expiration date of one year from the original date of service.

Soft & RGP Contact Lens Exam Fees:

New Exams:	$100 - $200
Annual Adjustments:	$75 - $150

Dispensing and Cancellations

Contact lenses are a medical device and therefore are non-refundable and cannot be returned. Orders may be cancelled or changed with no penalty if cancelled on the same day before close of business. Contacts must be picked up within 30 days after notification that the order is ready to be dispensed. Contacts not picked up within this timeframe will void any warranties and return policies. The order will be considered a cancelled order and no refunds or credits will be issued.

Signature of Patient or Legal Representative:_____

Date: _____