COASTAL
VISION CENTER

A Professional Optometry Corporation

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New Patient Information

Purpose of Today's Visit	□ Eye exam □ Medical Visit □ Other:	Last Eye Exam?	
Name		Nickname	
Date of Birth			
Sex	□ M □ F	Age	
Last 4 SSN		Marital Status	□ M □ S □ D □ W
Address		Unit	
City		State	
Zip			
Cell Phone		Home Phone	
Email		Preferred Language	□ English □ Spanish □ Other:
Employment Status	□ Employed □ Unemployed □ Retired	Occupation	
Emergency Contact and Relation		Phone Number	
Insurance	□ VSP □ EyeMed □ THIPA □ MES □ Davis Vision □ Medicare □ None	Who is responsible for the account?	
Medical Insurance		Type	□ HMO □ PPO

Medical History

Are you in good health?	□ Yes □ No	Do you have diabetes?	□ Yes □ No
Check if you have problems with any of these systems	□ Gastrointestinal □ Respiratory/Asthma □ Nervous System □ Ear/Nose/Throat □ Mental □ Headaches □ Endocrine (glands) □ Genitourinary □ Musculoskeletal □ Skin □ Cardiovascular □ High Blood Pressure □ Blood/Lymph/Cholesterol □ Other:		
Surgeries: What type and when?			
Current Medications: Include Vitamins/Supplements	□ See attached list of medications		
For medical purposes, what is your race?	□ American Indian or Alaska Native □ Asian □ Black or African American □ Native Hawaiian or other Pacific Islander □ White		
Are you allergic to medications or other substances?	□ Yes □ No	If so, please list:	
Your Primary Care Physician		When was your last physical?	
Your Ophthalmologist		When was your last visit?	
Do you smoke?	□ Yes □ No □ Former Smoker	If so, how much?	
Do you drink alcohol?	□ Yes □ No	If so, how much?	
Do you use other substances or recreational drugs?	□ Yes □ No	If so, please list:	
Personal Eye History	□ Glaucoma □ Macular Degeneration □ Eye Injuries □ Wear glasses □ Blurred Vision □ Eye Surgeries □ Cataracts □ Wear contact lenses		
Family Medical Eye History Please list what family members have a history of the disease(s)	□ Diabetes ________ □ High Blood Pressure ________ □ Glaucoma ________ □ Macular Degeneration ________ □ Cataracts ________ □ Retinal Detachment ________		
Would you be interested in learning more about LASIK today?	□ Yes □ No		
Do you suffer from dry eyes?	□ Yes, and I would like to complete your brief dry eye questionnaire □ No		
Your Interests & Hobbies	□ Sports & Fitness □ Electronics & Technology □ Crafts □ Photography □ Music □ Travelling		
Who may we thank for referring you?			

Please sign below to confirm that you have reviewed all of the information above and that it is correct to the best of your knowledge. Also, your signature below indicates that you have read and/or received a copy of the Notice of Privacy Practices of the Health Insurance Portability and Accountability Act (HIPAA). In addition, by signing below, you have certified that you and your dependent(s) have insurance coverage and assign all insurance benefits otherwise payable to the doctor(s) and understand that you are financially responsible for all charges whether or not paid by the insurance. You also authorize the doctor(s) to release all information necessary to secure the payment of benefits. Lastly, you authorize the use of this signature on all insurance submissions.

Signature: ________________________ ▪ **Date:** ________________