COASTAL VISION CENTER

A Professional Optometry Corporation

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***Face masks are required for office entry**

NAME		**NICKNAME**		**DATE OF BIRTH**	
SEX	□ M □ F □ Other □ Declined to specify	**LAST 4 SSN**		**MARITAL STATUS**	□ M □ S □ D □ W
ADDRESS				**UNIT**	
CITY,STATE, ZIP		**PREFERRED LANGUAGE**	□ English □ Spanish □ Other:		
CELL PHONE		**HOME PHONE**			
EMAIL		**OCCUPATION**		□ EMPLOYED □ UNEMPLOYED □ RETIRED	
EMERGENCY CONTACT/RELATION		**PHONE NUMBER**			
VISION INSURANCE	□ VSP □ EyeMed □ THIPA □ MES□ Davis Vision □ None	**PRIMARY MEMBER**			
MEDICAL INSURANCE		□ HMO □ PPO			

MEDICAL EYE & HEALTH HISTORY ● PLEASE CHECK ALL THAT APPLY

□ **Wear Glasses** □ **Wear Contact Lenses** □ **Glaucoma** □ **Macular Degeneration** □ **Eye Injuries** □ **Cataracts** □ **Eye Surgeries** **(please list on back of form)** □ **Joint/Muscle/Bone** □ Arthritis	□ **Central Nervous System** □ MS □ Parkinson's □ Alzheimer's □ **Cholesterol/ Blood/Lymph** □ **Lymphatic/Hematologic** □ Anemia □ Bleeding problems □ **HIV/AIDS**	□ **Endocrine** □ **Diabetes** □ Thyroid/Other Glands □ **Gastrointestinal** □ **Genitourinary** □Genitals/Kidney/Bladder □ **Cardiovascular** □ Hypertension □ Heart Disease	□ **Neurological** □ Headaches/Migraines □ Seizures □ Stroke □ **Psychiatric** □ **Cancer(s)** **Type:**	□ **Respiratory** □ Asthma □ Chronic Bronchitis □ Emphysema □ COPD □ **Ear/Nose/Throat** □ Allergies □ Chronic Cough □ Sinus Congestion □ **Other**

OTHER SURGERIES: TYPE/DATE	**MEDICATIONS/SUPPLEMENTS: TYPE/DOSAGE (USE BACK OF FORM IF NEEDED)** **COVID-19 VACCINE: ☐ 1ST SHOT ☐ 2ND SHOT ☐ BOOSTER ☐ OTHER**

FOR MEDICAL PURPOSES, SELECT RACE/ETHNICITY	□ Native American □ Asian/Pacific Islander □ Black/African American □ Hispanic/Latino □ White □ Other □ Decline to specify		
ALLERGIES TO MEDICATIONS OR OTHER SUBSTANCES?	□ Yes □ No	**PLEASE LIST:**	
PRIMARY CARE PHYSICIAN		**WHEN WAS YOUR LAST PHYSICAL?**	
OPHTHALMOLOGIST		**WHEN WAS YOUR LAST VISIT?**	
TOBACCO SMOKER?	□ Yes □ Never Smoker □ Former Smoker	**MARIJUANA SMOKER?**	□ Yes □ Never Smoker □ Former Smoker
USE VAPE PEN?	□ Yes □ Never □ Former	**ALCOHOL?** □ Yes □ No	**HOW MUCH?**
RECREATIONAL DRUGS/SUBSTANCES? PLEASE LIST			

FAMILY HISTORY/MEMBER	□ Diabetes	□ Mother □ Father □ Grandmother □ Grandfather □ Sibling
	□ Hypertension	□ Mother □ Father □ Grandmother □ Grandfather □ Sibling
	□ Glaucoma	□ Mother □ Father □ Grandmother □ Grandfather □ Sibling
	□ Macular Degeneration	□ Mother □ Father □ Grandmother □ Grandfather □ Sibling

ARE YOU INTERESTED IN LEARNING ABOUT LASIK?	□ Yes □ No	**DO YOU SUFFER FROM DRY EYES?**	□ Yes □ No
WHO MAY WE THANK FOR REFERRING YOU?			

By signing below I confirm that all of the information above is correct to the best of my knowledge. I hereby consent to the use and disclosure of my protected health information for purposes of treatment, payment, and health care operations. I am aware I can request a copy of Notice of Privacy Practices of the Health Insurance Portability and Accountability Act (HIPAA) and it will be provided. I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical or vision benefits either to the physician or supplier of services rendered or to myself if the Provider does not accept assignment. I understand that I am responsible for any balance my insurance does not pay. Lastly, I authorize the use of this signature on all insurance submissions.

Signature: _____ ▪ **Date:** _____