Intracoastal EYE

GREGORY J. JOHNSON
M.D., M.B.A., F.A.A.O.

PATIENT INFORMATION:

Name: _____
Last First Middle

Address: _____
Street City State Zip

County: _____ Email Address: _____ Language: _____

Home Phone: (____) _____ Work: (____)_____ Cell: (____)_____

Birth Date: _____ SS#: _____ Marital Status: _____ Employer: _____

Sex: ❑ M ❑ F	Race: ❑ White/Caucasian ❑ Asian ❑ Other race ❑ Black/African American ❑ Native Hawaiian or Pacific Islander ❑American Indian/Alaskan ❑ Declined to Specify	Ethnic Origin: ❑ Hispanic ❑ Non-Hispanic ❑ Declined to Specify

OTHER PROVIDERS: Primary Care Provider: _____ Other Eye Doctor: _____

Endocrinologist: _____ Rheumatologist: _____

Preferred Pharmacy: _____ Pharmacy Location / Number:_____

INSURANCE: ****You must bring your insurance card (s) and driver's license to your appointment****

Medical Insurance Co. _____
Policy# _____
Group# _____
Subscriber's Name _____
Subscriber's SS# _____
Patient's Relationship to Subscriber _____
Date of Birth _____

Vision Insurance Co. _____
Policy# _____
Group# _____
Subscriber's Name _____
Subscriber's SS# _____
Patient's Relationship to Subscriber _____
Date of Birth _____

Patient Signature _____ Date/Time _____

Responsible Party Signature _____ Date/Time _____

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www.intracoastaleye.com

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AUTHORIZATION for USE and/or DISCLOSURE of PROTECTED HEALTH INFORMATION

Patient's Name:_____ Date of Birth: _____

I authorize the use and/or disclosure of my protected health information to Intracoastal Eye Physicians. I understand that this authorization is voluntary and I may refuse to sign this authorization.

I understand that, if the persons or organizations I authorize below are not health care providers, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

YES/ NO: May we discuss details regarding your care, test results, billing information, or appointment information with someone else other than you? If yes, **name specifically any family, friends, and/or others authorized** to which we may release your protected health information either in writing or verbally:

_____	_____	_____
Name	Relationship	Phone number
_____	_____	_____
Name	Relationship	Phone number

YES/NO: May Intracoastal Eye leave medical information regarding my care (i.e. lab results, medications) or appointments on an answering machine? If yes, please do so on this number: (_____)_____.

I acknowledge that I have been made aware of Intracoastal Eye Physicians' **Notice of Privacy Practices** and a copy is available at my request. I have had full opportunity to read and consider the contents of the Intracoastal Eye Physicians Notice of Privacy Practices.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Signature: _____Date: _____

If this authorization is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

Intracoastal Eye Physicians Privacy Officer, 6740 Rock Spring Road, Suite 100 Wilmington, North Carolina 28405
Phone: (910) 777-8254 Fax: (910) 769-1246 Email: rjohnson@intracoastaleye.com

INTRACOASTAL EYE PHYSICIANS HISTORY AND INTAKE FORM

Name : _____ DOB: _____ MR#: _____

PAST MEDICAL HISTORY (please mark all that apply)

- ❑ Acid reflux/heartburn
- ❑ Aneurysm
- ❑ Bone/joint disorder
- ❑ Cancer (type and treatment)
- ❑ Chronic pain or migraines
- ❑ Depression/anxiety/mood disorder
- ❑ Diabetes (insulin dependent?)
- ❑ Lung disease (COPD/emphysema, asthma)
- ❑ Heart problems (heart attack, stents, atrial fibrillation, valve problems, pacemaker or defibrillator)
- ❑ Hepatitis or other liver disease
- ❑ High blood pressure
- ❑ HIV
- ❑ Kidney disease
- ❑ Neurologic (nerve) disorder/seizures
- ❑ Radiation therapy
- ❑ Rheumatologic disorder
- ❑ Sinus/nasal surgery/infections/allergies
- ❑ Skin cancer (type and treatment)
- ❑ Stroke or TIA
- ❑ Thyroid disease

Please provide details/other conditions:

PAST SURGICAL HISTORY (please mark all that apply)

- ❑ Problems with anesthesia/sedation
- ❑ Prolonged bleeding in you/family member
- ❑ Heal slowly
- ❑ Keloid (form bad scars) or heal poorly
- ❑ Allergy to LATEX or BETADINE
- ❑ Any type of heart surgery/procedure (stents, bypass, valve surgery, transplant)
- ❑ Procedure on arteries/blood vessels
- ❑ Joint replacement (hip, knee, shoulder)
- ❑ Any type of surgical implant/stent/plates?
- ❑ Neck or back surgery
- ❑ Facial/nose/sinus surgery or injury
- ❑ Spleen removed
- ❑ Please provide details/dates of any hospitalization(s) in the last 5 years:

Please provide details/other conditions:

OCULAR HISTORY AND SURGERY (please mark all that apply)

- ❑ Amblyopia (lazy eye)
- ❑ Blepharitis
- ❑ Cataract/cataract surgery
- ❑ Corneal disease/surgery
- ❑ Diabetic retinopathy
- ❑ Drooping eyelids
- ❑ Dry eye syndrome
- ❑ Eye muscle surgery/crossed eyes
- ❑ Glaucoma/glaucoma surgery
- ❑ Macular degeneration
- ❑ Retinal disease/surgery
- ❑ Any type of eye laser surgery?
- ❑ Prior eyelid surgery or injury
- ❑ History of Bell's palsy or stroke affecting facial muscles
- ❑ Prior tear duct, sinus or nose surgery
- ❑ Prior eye socket surgery or injury
- ❑ Prior facial surgery or injury
- ❑ Family History (please list eye and other diseases that run in your family)

Please provide details/other conditions:

MEDICATIONS (please list all current medications, supplements, vitamins, and pain relievers along with the strength and how often you take them)

1- _____ 2- _____

3- _____ 4- _____

5- _____ 6- _____

7- _____ 8- _____

9- _____ 10- _____

11- _____ 12- _____

13- _____ 14- _____

ALLERGIES (please include all medication and other allergies and the reaction you have had)

1- _____ 2- _____

3- _____ 4- _____

5- _____ 6- _____

TOBACCO HISTORY (please respond to each section)

Smoking/Tobacco:

- ☐ Never
- ☐ Quit_____(year) after ____years
- ☐ Smokes _____ packs per day
- ☐ Other tobacco usage:_____

REVIEW OF SYSTEMS (please mark active problems below and explain to our staff)

- ☐ None
- ☐ General (fever, weight loss, fatigue)
- ☐ Eyes (not already included above)
- ☐ Ear/nose/throat (infections, drainage)
- ☐ Heart or blood vessels (chest pain)
- ☐ Lungs (shortness of breath, cough)
- ☐ Digestion (reflux, vomiting, diarrhea)
- ☐ Nerve system (headaches, numbness)
- ☐ Kidneys, urinary, or gender organ problems
- ☐ Muscle, bone, or joints
- ☐ Endocrine (diabetes, thyroid)
- ☐ Allergies/immune system
- ☐ Blood (anemia, bleeding, clotting)
- ☐ Skin (rash, rosacea, psoriasis)
- ☐ Psychiatric (depression, anxiety, mood)

Please provide details: _____

Intracoastal
EYE

What is a Refraction?

A **Refraction** is the process of determining the need for eyeglasses or a change in one's prescription. A refraction is necessary to write a prescription for glasses or contact lenses, and to help diagnose medical conditions affecting your eyes.

Most Medical Insurance plans, including Medicare, do **NOT** pay for refractions. The refraction fee is a separate charge from the eye examination fee. Our office fee for a refraction is $50.00 and is collected at the time of service in addition to any co-payment your plan may require. If you wish to forego the refraction, please inform us BEFORE the test is performed.

Signature _____ Date _____

Intracoastal Eye Financial Policy

INITIAL

_____You will be responsible for any co-pays, deductibles, coinsurances, and any non-covered services or screening that your insurance does not pay.

_____It is your responsibility to know your plan and plan benefits. Intracoastal Eye will submit your claim for services to your insurance company on your behalf.

_____If your insurance company requires an authorization, you will be responsible for getting one prior to your visit. If no authorization is in place, you accept full financial responsibility.

_____Statements are mailed out monthly for outstanding balances. Financial arrangements can be made with our office manager if needed.

_____If your account balance becomes past due it will be sent to an outside collection agency and you will be responsible for any additional fees incurred.

_____The adult parent or guardian accompanying a minor is responsible for payment of the minor patient's account regardless of the name listed as the insurance policy holder.

_____Intracoastal Eye accepts cash, check, Mastercard, Visa, American Express, and Discover.

Signature _____ Date _____

Intracoastal
EYE

Intracoastal Eye Contact Lens Agreement

Thank you for entrusting Intracoastal Eye with your contact lens needs. We offer the latest contact lenses for a wide variety of visual conditions, including nearsightedness, farsightedness, astigmatism, and age-related decline in near vision. We also specialize in complex contact lens fittings, including keratoconus and other anterior segment diseases. Dr. Johnson and our staff are dedicated to your eye health and an enjoyable, comfortable contact lens experience.

In addition to a refraction (determining your glasses prescription), an annual **Contact Lens Evaluation** is necessary to ensure that your vision is optimized, the contact lenses fit properly, and that the contact lenses are not adversely affecting the health of your eyes. Most insurance companies do not cover charges related to contact lenses.

Our **Contact Lens Evaluation** fees are as follows, payable at the time of service:

- Soft Spherical $85
- Toric (astigmatism) $105
- Monovision $125
- Multifocal $125
- Rigid Gas Permeable $150
- Specialty (keratoconus, aniridia, hybrid, etc.) $350

If you have **never worn contact lenses before**, you will be scheduled for a training session with a contact lens technician. During this session, patients are taught how to safely insert, remove, clean, and care for contact lenses. The **Contact Lens Training Session** fee is $90 in addition to the Contact Lens Evaluation fee.

All Contact Lens Services include 90 days of follow up for any necessary adjustments.

Patient signature _____ Date_____