Dr. Coker Family Eye Care
Welcome to our Office

Patient Information

Last Name:_____First Name:_____MI_____
Preferred Name:_____DOB:____/____/_____ SSN_____-_____-_____
Address:_____City:_____ST:_____ Zip Code:_____
Home Ph: (____)_____-_____Cell Ph:(____)_____-_____ Work Ph:(____)_____-_____Extension:_____
Email:_____@_____Preferred Phone Number: (Home) (Cell) (Work)

Emergency Contact:_____Relationship:_____Phone Number:(____)_____-_____
Empolyer(or School):_____Occupation(or Grade)_____

Primary Care Physician:_____Date of Last Physical Exam:_____
Date of Last Eye Exam:_____ By Whom:_____City:_____

Reason For todays visit:_____

Do You Currently wear Glasses? (Y) (N) Do You Wear Contact Lenses? (Y) (N)
If Not, Are You Interested in Contacts (Y) (N)

Are there any problems with your current glasses or contact lenses?_____

Very Important! New Patients Only:
Who may we thank for Referring you?

Name of friend or relative:_____

If not referred, how did you hear about our office?

- ☐ Another Doctor
- ☐ Insurance List
- ☐ Saw Building/ Sign
- ☐ Web Page: Which website?:_____
- ☐ School/ Health fair Flyer

Insurance Information

Please present BOTH Medical and Vision Cards

Vision Insurance:_____Insured ID#:_____

Primary Insurance Holders Name:_____DOB____/____/_____SSN:_____-_____-_____

Relationship to Patient (Please Circle): SELF SPOUSE PARENT

Medical Insurance:_____Insured ID#:_____

Primary Insurance Holders Name:_____DOB____/____/_____SSN:_____-_____-_____

Relationship to Patient (Please Circle): SELF SPOUSE PARENT

Our mission at Dr. Coker Family Eye Care is to provide the highest quality of eye care in order to achieve a lifetime of great health and vision. We pride ourselves on creating a family friendly atmosphere while serving you with the most advanced forms of testing and treatment.

This is our promise to you.

Patient Medical History

Current Medications(BOTH Rx & Over the Counter)
(List name of ALL Medications including eye drops, vitamin supplements, & birth control pills)_____

_____

_____

*Name of Pharmacy:*_____

*Pharmacy Location:*_____

Pharmacy Phone Number: (____)____-_____

Allergies to any medications? □Yes □No
If so, what medications?

_____

_____

Have you had any surgeries? □Yes □No
If so, please list procedure and year:_____

_____

Do you use *(or have you used)* □Yes □No
tobacco products?
If so, Please choose one.

- □ Current everyday
- □ Current occasional
- □ Former

Have you ever been diagnosed or treated for any of the following health conditions? If so, please choose box and explain.

Neurological
□Yes □No _____
Gastrointestinal
□Yes □No_____
Hematologic/ Lymphatic
□Yes □No_____
Allergic/ Immunologic
□Yes □No_____
Musculoskeletal
□Yes □No_____
Integumentary (Skin)
□Yes □No_____
Genitourinary
□Yes □No_____
Ear, Nose, Throat
□Yes □No_____
Respiratory
□Yes □No_____
Eyes
□Yes □No_____
Cardiovascular
□Yes □No_____

***Diabetes*
□Yes □No
***If so, please answer the following:*

□ Type 1 □Type 2 □Gestational □Prediabetes
Duration of Diabetes (in years): _____ years
Current Diabetes Therapy:

□Insulin □Oral Hypoglycemic □ Diet Control □None
Results of last finger stick blood glucose reading: _____

Family Medical/Eye History

Is there a family history of any of the following?
**If so, Please check box(es) and list relationship.

Blindness
□Yes □No _____
Cataracts
□Yes □No _____
Corneal Problems
□Yes □No_____
Diabetes
□Yes □No_____
Diabetic Retinopathy
□Yes □No _____
Glaucoma
□Yes □No _____
Heart Disease
□Yes □No _____
Lazy Eye
□Yes □No _____
Macular Degeneration (AMD)
□Yes □No _____
Retinal Problems
□Yes □No _____

Dilation or Photos are required for a full health examination. (Photos allow the doctor to examine the health of the back of your eyes without the side effects of dilation.) Dilation side effects include light sensitivity and blurred near vision for up to 6 hours. **Please circle and sign below:**

Yes, I would like Photos ($25.00 additional) / No, I would like to dilate (Included in Exam price)

Signature_____ Date_____

~The sensitivity and specificity of digital photography techniques are not as high as those of traditional fundus evaluation(Dilation). ~

Please be advised if you are using insurance coveragefor todays visit, this is a contract between you and your insurance company, not Dr. Coker Family Eye Care.

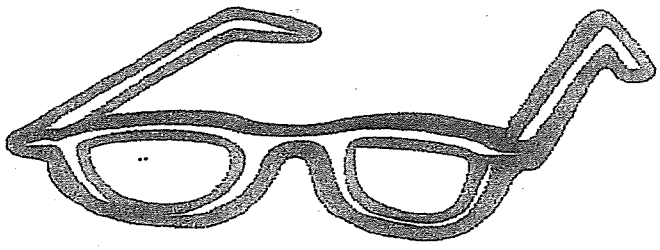
If your insurance company has not reimbursed our office within 90 days you will be billed for the charges rendered on that date of service. I understand that (regardless of my insurance status), I am ultimatly responsible for the balance on my account for any professional services rendered. I have read and comlpeted the information above and I certify this to be true and accurate to the best of my knowledge. I will notify the office of any changes in my status.

*Signature*_____*Date*_____

It is often necessary to use and disclose health informationin order to treat you, to obtain payment for our services, and to conduct healthcare operations involving our office. "The Notice of Privacy Practices" you have been given describes the uses and disclousers in detail. I aknowledge that I received the Notice of Privacy Practice" form Dr. Troy Coker, OD.

*Signature*_____*Date*_____

*****We reserve the right to charge a $25.00 fee for any appointment Cancelled, Broken, or Rescheduled without 24 hours advanced notice.*****



Dr. Coker Family Eye Care

Health Information Release

The privacy laws limit our ability to communicate protected health information without your written consent even to family members or next of kin. Please indicate those who you authorize us to release information. Your signature permits release of information effective from the date signed until such time that you revoke it in writing. If you wish information release to no one but yourself, enter "Myself Only" on the first line.

Name	Relationship	All Info	Schedule	Billing

All information I have provided to this office is accurate to the best of my knowledge. I have read and understand the contents of this consent form.

Signature of Patient or Responsible Party_____Date_____

Signature of office Representative_____Date_____