Marguerite Cote, O.D., P.A.

Welcome

We are pleased that you have chosen our practice and are looking forward to taking care of all your ocular needs. Take a moment to tell us about yourself. If you have any questions we will be glad to help you.

Patient Information

Name_____Gender_____DOB____/_____/____
Address_____Soc. Sec#_____/_____/_____
City_____State_____Zip_____
Telephone(____)_____Cell_(___)_____E-Mail_____
Who referred you to our practice? Self___Another patient_____
Patient Employed by_____Occupation_____
Preferred Language_____Race/Ethnicity_____

Account Responsible (if different from above)

Person responsible for Account_____
Preferred phone_____

Health Insurance Information*

Health plan _____
Subscriber's Name _____
Subscriber's Address_____
City_____State_____Zip_____
Relation to Pt _____
Subscriber's DOB _____
Subscriber's Employer _____
Any deductible? _____ Amount? _____
Do you need a referral from your PCP for this visit? _____
Primary Physician Name _____
Primary Physician Phone # _____

Vision Plan Information

Vision Insurance Plan _____
Subscriber's Name _____
Subscriber's Address_____
City_____ State_____Zip_____
Relation to Pt _____
Subscriber's DOB _____
Subscriber's SS # _____/_____/_____
Subscriber's Employer _____

***Many medical eye problems are covered by insurance. We ask for your most recent insurance card at the time of your visit so a copy may be included in your record. If referrals are needed for us to bill your insurance properly, please let us know.**

Payment Authorization—I authorize payment of all vision benefits for services and/or materials rendered directly to the doctor or provider as indicated. I understand that I am responsible for any payments not covered by the insurance plan and services rendered and materials dispensed are not refundable. I also hereby authorize the release of information regarding my medical and vision history for the purpose of validating and determining benefits payable in connection with the insurance claim.

_____ _____

Patient/Parent/Guardian Signature Date

Patient's Eye History

Are you currently experiencing any of the following problems with your eyes?

☐Blurred vision
☐ Loss of vision
☐Loss of side vision
☐Distorted vision
☐Double vision
☐Tired eyes
☐Floaters in vision
☐Halos
☐Glare/light sensitivity
☐Dryness
☐Foreign Body sensation
☐Burning
☐Itching
☐Redness
☐Excess tearing/watering
☐Eye pain or soreness
☐Mucous discharge
☐Chronic eye or lid infection
☐Styes or chalazion

Have you or any relative ever been diagnosed with any of the following ocular problems?

Self	Relative
☐Cataracts_____	☐_____
☐Crossed eyes_____	☐_____
☐Eye injury_____	☐_____
☐Glaucoma_____	☐_____
☐Lazy Eye_____	☐_____
☐Macular Degeneration_____	☐_____
☐Retinal Degeneration_____	☐_____
☐Drooping eyelid(s)_____	☐_____

Do you currently take any medicines or drops for your eyes? If so, which ones?_____

NEW PATIENTS ONLY

When was your last eye exam? _____ **What doctor?**_____
Have you ever been dilated? _____ **When?**_____

Do you currently wear glasses?_____**How old are they?**_____
Are they single vision lenses or bifocal lenses (line or no line)?_____
Do you have a copy of your most current eyeglass prescription?
Do you have any specific needs for your glasses such as safety eyewear, sports specs, tinted lenses or lightweight, thinner lenses?

Do you currently wear contacts?_____**What brand?**_____
Do you ever sleep in your lenses?_____**If so, how often do you remove them?**_____
Do you need to lubricate your eyes?_____**Preferred wetting drop**_____
What solutions do you prefer?_____
Are you sensitive to any solutions?_____
Do you have a copy of your most current contact prescription?

PLEASE LIST ALL OF YOUR MEDICINES

_____**Mg**_____

_____

_____

_____

_____

_____

___

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

Allergy/Immunologic

☐Allergies:_____

☐Allergies to medications /Which ones?_____

Cardiovascular

What is your Blood Pressure? _____/_____

☐Heart Disease

☐High Blood Pressure

☐High Cholesterol

Constitutional

What is your height?_____

What is your weight?_____

Social History

Do you….

☐Smoke__ How much?_____

☐Consume alcohol__ How much?_____

☐None of the above

Endocrine

☐Diabetes

☐Thyroid

Genitourinary

☐Ovarian/Uterine Cancer

☐Prostate Cancer/disorder

Gastrointestinal

☐Ulcers

☐Crohn's disease

Hematologic/Lymphatic

☐Anemia

☐Bleeding Problems

☐Breast Cancer

Skin

☐Cancer

☐Rashes

☐Easy bruising

Musculoskeletal

☐Rheumatoid ☐Joint pain

☐Osteoporosis ☐Muscle pain

Neurological

☐Headaches

☐Seizures

☐Dizziness

☐Stroke

☐Parkinson's

☐MultipleSclerosis

Psychiatric

☐Anxiety

☐Depression

☐Memory Loss

☐ADHD

Respiratory

☐Asthma ☐Bronchitis ☐Emphysema

Your Privacy

In the course of providing service to you, we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services and to conduct health care operations involving our office.

The Notice of Privacy Practices available in our office describes these uses and disclosures in detail. You are free to refer to this notice at any time before you sign this form. As described in our Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and service provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow-up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment include (1) our submission of your health information to a billing agent or vendor for processing claims or obtaining payment; (2) our submission of claims to third party payers or insurers for claims review, determination of benefits and payment; (3) our submission of your health information to auditors hired by third party payers and insurers; and (4)other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office.
When you sign this consent document, you signify that you agree that we can and will use and disclose your health information to treat you, to obtain payment of our services and to perform healthcare operations. You also signify that you have received a copy of our health information for purposes of treatment, payment, and of our Notice of Privacy Practices.

You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obliged to agree to these suggested restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for a restriction.

I have read this document and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment and healthcare operations. I acknowledge that I have received the Notice of Privacy Practices from Dr. Marguerite Cote, O.D., P.A.

Signature:_____Date:_____

Relationship to patient_____ Print name_____

Patient Record of Disclosures

I wish to be contacted in the following manner (check all that apply)
☐Home telephone_____☐Work telephone_____
☐OK to leave a detailed message ☐ leave message with only call back number
☐Written communication
☐OK to mail to home address☐ OK to mail to work/office☐ OK to fax to_____
☐Email _____

Please note: Uses and disclosures for TPO (Treatment/Payment/Healthcare Operations) may be permitted without consent in the case of an emergency.

Patient/Parent/Guardian Signature:_____Date:_____

FOR OFFICE USE ONLY

Date	Disclosed to Whom	Address or Fax #	Disclosed by Whom	Time