SHORELINE EYECARE

PATIENT REGISTRATION FORM

(please print)

Today's Date:

Patient Information

Last Name	First	MI	☐ Male ☐ Female	Date of Birth	SS#
Address	City	State	Zip	Marital Status ☐ Single ☐ Married ☐ Divorced	
Cell#	Home#	Ethnic Background	E-Mail		
Occupation	Employer	Emergency Contact & Phone Number			
Responsible Party (for minors)	Relationship	Responsible Party's Contact Number			

Medical History

List all medications currently taking *(prescription and over the counter)* ☐ **None**

List all drug allergies you have *(& please explain)* ☐ **None**

Please check those that apply: ☐ **CHECK HERE IF NONE APPLY**

ENT
- ☐ Dry Mouth
- ☐ Hearing Loss
- ☐ Sinusitis

Endocrine (Hormones)
- ☐ Diabetes
- ☐ Thyroid Problems

Gastriontestinal
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Ulcer

Genitourinary
- ☐ Hepatitis
- ☐ STD - Herpes/Chlamydia
- ☐ Syphilis

Respiratory
- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Obstruction
- ☐ Emphysema

Hemotologic/Lymphatic
- ☐ Anemia
- ☐ Cancer
- ☐ High Cholesterol

Integumentary
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rosacea

Psychiatric
- ☐ Anxiety/Panic Attacks
- ☐ Bipolar
- ☐ Depression

Cardiovascular
- ☐ Congestive Heart Failure
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Vascular Disease

Allergic (Immune)
- ☐ Drug Allergies
- ☐ HIV/AIDS
- ☐ Lupus
- ☐ Rheumatoid Disorder
- ☐ Seasonal Allergies

Constitutional
- ☐ Chronic Fatigue Syndrome
- ☐ Development Disabilities
- ☐ Headaches/Migraines
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis

Others
- ☐ Alcohol-use
- ☐ Recreational Drug-use
- ☐ Tobacco-use (ever)
- ☐ Pregnant
- ☐ Other _____

Family History: (Diabetes, Hypertension, Glaucoma, Macular Degeneration, etc)

Family Physician Name & Phone:

Please check those that apply: ☐ **CHECK HERE IF NONE APPLY**

- ☐ Burning
- ☐ Itching
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Pain
- ☐ Glare/Light Sensitivity
- ☐ Blurry Vision
- ☐ Double Vision
- ☐ Seeing Floating Spots
- ☐ Seeing Flashing Lights
- ☐ Previous Eye Injury
- ☐ Previous Eye Surgery
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Lazy Eye/Eye Turn
- ☐ Eye Patching
- ☐ Retinal Detachment

Do you currently wear contact lenses? ☐ Yes ☐ No

If yes, what type/brand?

Office Use Only:

Current Rx:

PLEASE COMPLETE OTHER SIDE

Thank you for choosing Shoreline Eyecare for your optical needs!

Please take a moment to review our privacy policies . Feel free to ask questions if anything is unclear!

Financial Policy Statement

We at Shoreline Eyecare, are committed to providing you with the highest quality service available. We ask that you carefully read and sign the following policy. Please be advised that, as your eye care provider, our relationship is with you and not your insurance carrier. As a courtesy to you, we will check your insurance benefits on your behalf as well as file your claim with the insurance company. However, you are the sole responsible party for all charges incurred and guarantee payment thereof. If we are contracted with your insurance company, including Medicare, we will accept assignment. Please note, Medicare *does not* cover routine eye exams or refractions. You will be responsible for your payment portion at the time of service. Failure to provide necessary referrals and/or authorizations or failure to provide current, accurate billing information will result in all charges for services becoming the sole responsibility of the patient/responsible party. We encourage you to check with your insurance carrier and understand your benefits, coverage and responsibility prior to your visit. All co-pays, co-insurances, deductibles, and contact lens fees are due and payable at the time service is rendered. Most insurance plans *do not* cover contact lens related services. The contact lens fee will cover for fitting, evaluation and follow up services for up to 60 days after your initial visit and is non-refundable. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payments at the time services are rendered.

Refund/Return Policy: No refunds are made on clinical procedures or services including eye examination, refraction, contact lens related evaluation/fitting and medical office visits. For optical products such as frames, we offer a 14 day exchange guarantee from the date of dispense given that the frame is in its original condition. For prescription lenses, we offer a 90 day exchange guarantee. We will remake your lenses in a different material and/or design given that progressive lens wearers have given at least 14 days to adjust. Unopened, undamaged, unexpired boxes of contact lenses can be returned for store credit towards glasses or exchanged within 90 days from date of dispense. Opened and/or damaged boxes of contact lens are non-refundable.

Patient Authorization

I hereby assign/transfer payment benefits made to me and my behalf to Shoreline Eyecare for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.
I hereby authorize Shoreline Eyecare to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

HIPAA Notice of Privacy Consent

- I understand that my health information is private and confidential. I understand that Shoreline Eyecare works hard to protect my privacy and preserve the confidentiality of my health information.
- I understand that Shoreline Eyecare may use and disclose my health information to provide treatment to me, the patient, to handle billing and payment, and to take care of other healthcare operations.
- I understand that I may receive email and/or text communications from Shoreline Eyecare such as appointment reminders, recalls and updates.

You may review our complete Notice of Privacy Practices on our website http://www.shorelineeyecare.com. We reserve the right to change our privacy practices at will and you may obtain any revised notices. You also have the right to request a restriction of how your protected health information is used, however, we are not required to agree to the request. If we agree to your requested restriction, we must follow the restriction. You may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

By signing below, I acknowledge that I have read and understand the above statements and wish to have services and or procedures performed at Shoreline Eyecare.

Signature (Patient or Legal Representative)	PRINT NAME	DATE

Annual Contact Lens Service Fees

Contact lenses are medical devices that require proper care and monitoring to ensure good vision and ocular health. **A Contact Lens Service or "Fitting" is the time and knowledge required to prescribe the most appropriate contact lenses for you and your eyes.** This service is in addition to your annual eye health exam and is typically not covered by vision plan exam benefits. The contact lens service fee varies by the complexity of your eyes, the type of contacts you require, and the amount of time necessary to achieve a proper fit. This fee is due at the time of your annual exam and is nonrefundable.

The service fee covers all "fit-related" follow-up visits for 3 months from the initial evaluation. Any changes after 6 months from the initial evaluation will require a new comprehensive eye exam charge. Contact lens service fees for the most commonly used lenses are listed below:

Spherical Soft Contact Lenses	$75
Toric Soft Contact Lenses	$85
Multifocal Soft Contact Lenses	$95

If you are a first time wearer of contact lenses a $35 fee will be charged for a contact lens lesson.

I have read and understand the Contact Lens Service policies of Shoreline Eyecare.
Initial_____

I would like my Contact Lenses evaluated and my prescription updated:

Please Circle: Yes No