GOLD COAST EYE ASSOCIATES LLC.

5065 Main Street #1140
Trumbull, CT 06611
(203)-374-3211

PATIENT INFORMATION (Please print clearly, thank you.)

Last Name______________________ First Name_____________________ MI_____ Birthdate_______/_______/___________
Address_______________________________________ City________________________ State_____ Zip____________________
Telephone Home (_________)_____________________________ Cell(_________)_________________________________
E-Mail____ Social Security No.____________/______________/__________
Occupation____ Employer____
Credit Card___________________________________ Exp Date________________________________ CVV___________________

RESPONSIBLE PARTY (GUARANTOR) INFORMATION

(If patient is under 18 years of age)

Last Name_______________________ First Name______________________ Relation to Patient _________________________
Birthdate _____/_____/______Primary Phone(_______)________________

INSURANCE INFORMATION

Do you have medical insurance? No_____ Yes_____ Please list carrier____
Do you have vision insurance? No_____ Yes_____ Please list carrier____
Subscriber No.______________________________ ___________ Group No.____________________ ______________________
Policy Holder: (if other than patient)
Last Name________________________ First Name_____________________ Relation to Patient________________________
Birthdate _____/_____/______Primary Phone (_______)________________ Social Security No._____/_____/________

PATIENT HISTORY

How long has it been since your last eye exam? ____
What is your primary reason for today's exam? ____
Do you or any blood relatives have diabetes? No_____ Yes_____
Are you currently taking any medications? No_____ Yes_____
Are you allergic to any medication? No_____ Yes_____
Do you have high blood pressure? No_____ Yes_____
Are you currently pregnant? No______ Yes______ N/A____
Have you ever had any eye disease, injury or surgery? No_____ Yes_____
Do you ever see double? No_____ Yes_____
Do you have frequent headaches? No_____ Yes_____
Do you or a blood relative have cataracts? No_____ Yes_____
Do you or a blood relative have glaucoma? No_____ Yes_____
Do you or a blood relative have macular degeneration? No_____ Yes_____

CONTACT LENS INFORMATION

Are you interested in wearing contact lenses? No_____ Yes_____
Are you a new wearer to contact lens? No_____ Yes_____
Current brand of contact lens____ Comfort issues? No_____ Yes_____
Current RX for contact lens____ Dryness issues? No_____ Yes_____

FOR OFFICE USE ONLY

Insurance Copay______________ Contact Fit Allowance_______________ Contact Allowance________________________

Type of Exam: Routine EE CL Fit Office Visit **Type of CL Fitting:** Spherical Toric MF Monovision RGP

Retinal Photos No_____ Yes_____ Account Number_____________________________________

GOLD COAST EYE ASSOCIATES LLC.

The current insurance providers that we file with are: EYEMED, AETNA VISION NETWORK, BLUE VIEW VISION, HUMANA VISION, VSP*, CONNECTICARE, ANTHEM BLUE CROSS BLUE SHIELD, UNITED HEALTH CARE, HUSKY/STATE OF CONNECTICUT. We only file primary insurance. We will provide you with proper receipts so that you can file with your insurance plan.

FINANCIAL POLICY

Full payment is due when services are rendered. Insurance must be presented, and member eligibility obtained on the date of service for insurance to be filed. We accept cash, Visa, MasterCard, & Discover. We do not accept *American Express, checks, & CareCredit*. Refunds will not be issued on services. Eyeglass and contact lens prescriptions are valid one year from the date of exam. By signing this form, you are giving us permission to submit an insurance claim on your behalf if Insurance Information was provided. You are also giving us permission to process your credit card that's on file, when services are rendered, goods are purchased, or fees are incurred. A **no-call no-show** policy means you'll be charged a $100.00 penalty charge for failure to come to your appointment without notifying Gold Coast Eye Associates in a timely manner. This also applies if patient fails to show up to their appointment on time, please be aware that if you are more than 10 minutes late, we might also consider you as a **no-call no show**.

INSURANCE CLAIMS

Gold Coast Eye Associates LLC. is a participating office with the insurances only listed above. Which means Gold Coast Eye Associates, agrees to abide by the terms of those contracts only.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for all services rendered. I understand that ROUTINE eye examinations may not be considered medically necessary by insurance plans and I agree to be responsible for payment of such services.

I hereby authorize Gold Coast Eye Associates LLC., to furnish information to insurance carriers concerning my illness if any, treatments, and assign to the doctor(s) all payments for medical services rendered to myself or dependents. I request that payment or any insurance benefits be made either to me on my behalf to Gold Coast Eye Associates LLC. for any services furnished to me by the doctor. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

MINOR PATIENTS (UNDER THE AGE OF 18)

The adult(s) accompanying a minor and/or the parent or guardian are responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied unless we have consent from the parents or legal guardian.

CONTACT LENS PATIENTS

Refunds will not be issued on services that have been rendered. A contact lens evaluation does not guarantee any patient will be able to wear a contact lens successfully. If patients are new wearers to contacts, an insertion and removal training class must be successfully completed in order to dispense and finalize contact lens.
Opened, damaged or marked contact lens boxes may not be returned or exchanged. Exchanges or returns must be made within 30 days of purchase date.

Your eyes may be dilated, and you may need someone to drive you home

I have read, understood and agree to the above information. I certify this information is correct to the best of my knowledge, I will notify you of any changes in my health status or the above information.

Signature Print Name Date