SHORELINE EYE GROUP

Patient Registration Form

Patient's Name (Last, First, MI): _____

Patient's Home Phone Number: _____ Alternate Phone Number (☐ cell or ☐ work): _____

E-Mail Address: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Sex: M F

Race (optional): _____

Ethnicity (optional): _____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Widowed

Patient's Employer: _____

Employment Status: [ ] Full time [ ] Part time [ ] Unemployed
[ ] Retired [] Student [ ] Other: _____

Emergency Contact: _____ Relationship to Patient: _____

Address: _____ Phone number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

Secondary Insurance: _____

Patient is Subscriber/Policy Holder: Y N

INSURED INFORMATION (IF OTHER THAN PATIENT) - We will request to scan your ID and insurance card

Subscriber/ Policy Holder: _____ Relationship to Patient: _____

Address: _____

Social Security Number: _____

Date of Birth: _____

His or Her Employer: _____ Work Phone Number: _____

How did you hear about Shoreline Eye Group?

Indicate with your initials below that you have reviewed and/or completed prior to your appointment:

_____ I have been offered a copy of the Shoreline Eye Group P.C's notice of privacy practices.

_____ I have read, understand and agree to comply with the Shoreline Eye Group, P.C's insurance financial policies.

_____ I have completed a medical history form

I authorize payment of medical insurance benefits to be made directly to Shoreline Eye Group. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible for all charges not paid by my insurance, to include any procedure that is not covered under my insurance plan.

Patient / Parent or Guardian Signature: _____ Date: _____

Patient / Parent or Guardian Signature: ____ Date: ___________________

Patient / Parent or Guardian Signature: ____ Date: ___________________