



SHORELINE EYE GROUP
PATIENT REGISTRATION

Patient First Middle Last

Address Street/P.O. Box Apt # City State Zip

Email Language

Social Security# (Optional) Date of Birth

Home Phone # Work # Cell #

Gender M F Ethnicity (optional): Race (optional):

Marital Status: Primary Care Physician: Name: Phone#

Referring Doctor: Name Address Phone #

Policy Holder's: First Middle Last

Policy Holder's Address: Street/P.O. Box Apt # City State Zip

Policy Holder's Date of Birth: Gender: Phone #

Relationship to Patient:

How did you hear about Shoreline Eye Group?

Indicate with your initials below that you have received, reviewed and / or completed prior to your appointment: (forms are available for your viewing, online at www.shorelineeyegroup.com, or in the waiting area)

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 have submitted current insurance information.

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.

Signature: Date:

If Guarantor, relationship to patient: