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: _____