SHORELINE EYE GROUP PATIENT REGISTRATION

PATIENT_____

ADDRESS_____
Street/P.O. city state zip

EMAIL_____DATE OF BIRTH_____AGE_____

SOCIAL SECURITY #_____LANGUAGE_____

GENDER_____M_____F ETHNICITY(optional)_____RACE_____

PRIMARY PHONE #_____ BUSINESS PHONE #_____

MARTIAL STATIS_____ CELL PHONE #_____

EMERGENCY CONTACT PERSON_____

TELE#_____RELATIONSHIP_____

PERSON RESPONSIBLE FOR BILL_____

ADDRESS_____

TELE #_____RELATIONSHIP_____

HOW DID YOU HEAR ABOUT SHORELINE EYE GROUP?_____

INDICATE BELOW THE FORMS RECEIVED, 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 HAVE SUBMITTED CURRENT INSURANCE INFORMATION

I authorize payment of medical insurance benefits to be made directly to SHORELINE EYE GROUP. I understand that I am financially responsible for all charges not paid by my insurance, to include any procedure that is not covered by my insurance plan.

SIGNATURE_____DATE_____

If Guarantor, relationship to patient_____

Rev12/2015