

PATIENT INFORMATION

Salutation	Patient's Last Name		First Name		MI	Our Acct #
Social Security Number		Date of Birth	Sex	Marital Status	Language	
Home Street			City		State	Zip
Work Street			City		State	Zip
Home Phone <i>ok to leave message? []y []n</i>		Work Phone			Cell <i>ok to leave message? []y []n</i>	
Contact Preference			e-mail			
Occupation			Employer			
Primary Medical Doctor			Regular Optometrist or Optician (if any)			
Preferred Pharmacy (Name, Location)						
<i>Who referred you to our office, or why did you choose to see us (check all that apply)?</i> <input type="checkbox"/> doctor <input type="checkbox"/> family member <input type="checkbox"/> friend <input type="checkbox"/> insurance <input type="checkbox"/> internet <input type="checkbox"/> Yellow Pages <input type="checkbox"/> advertisement <input type="checkbox"/> general reputation. <i>Please specify:</i>						
<i>Who should we call in an emergency? Relationship to patient?</i>			Phone Number			

Primary Insurance	Group Number	Policy Number
Name of Policy Holder	Relationship to Patient <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> other	
Secondary Insurance	Group Number	Policy Number
Name of Policy Holder	Relationship to Patient <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> other	
Vision Plan, if any (for glasses/routine eye care)	Group Number	Policy Number
Name of Policy Holder	Relationship to Patient <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> other	

RESPONSIBLE PARTY (GUARANTOR OR INSURANCE SUBSCRIBER) INFORMATION

	Responsible Party's Last Name		First Name		MI	
Date of Birth			Relationship to Patient <input type="checkbox"/> self <input type="checkbox"/> spouse <input type="checkbox"/> parent <input type="checkbox"/> other			
Home Street			City		State	Zip
Work Street			City State			Zip
Home Phone		Work Phone		Cell		
Occupation			Employer			

Name: _____

Account Number: _____

PATIENT SIGNATURE PAGE

CONSENT TO EXAMINATION AND TREATMENT: I understand that the examination or treatment performed by the doctor may include dilation of the eyes and other procedures that may affect my vision. I understand that I may be temporarily impaired for driving, reading, the operation of machinery, and other tasks. I agree to make arrangements for my own transportation if needed. I agree to drive only if I believe my vision is adequate, and do so at my own risk and responsibility. If I do not wish to have my eyes dilated, I understand that it is my responsibility to notify the doctor and his/her assistants before drops are instilled, and that this may limit the completeness and extent of my examination and treatment.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION: If I do not pay for services rendered myself, I authorize the payment of my insurance benefits directly to Coastal Eye Specialists Medical Group, Inc. I understand that, while my insurance may assist me in paying for my medical expenses, I am financially responsible for the services provided to me. This includes payment for any copayments, deductibles, and services that are not covered by insurance.

FOR MINOR OR INCAPACITATED PATIENTS ONLY: If the patient is a minor or has been deemed incapacitated, I certify that I am a responsible parent/guardian/conservator for the patient, and hereby consent to the examination and treatment of the patient as judged necessary and advisable by the doctor.

COLLECTION AND RELEASE OF INFORMATION: I authorize you to electronically access and transmit my medical information (eg medical records, images, lab tests, pharmacy information) from and to other providers as needed to provide my medical care.

***PRIVACY NOTICE:** We are required by law to maintain the privacy of protected health information and to provide patients with our Notice of Privacy Practices, which describes how we may use and disclose your health information, your rights, and our legal obligations regarding this information. This Notice is posted in the reception area and on our web site (www.coastaleye.net). A copy is available for you to keep on request.*

PRIVACY NOTICE: I acknowledge that I have been provided a Notice of Privacy Practices.

Signed: _____

Date: _____

Print name: _____

If not signed by the patient, please relationship: _____

INSTRUCTIONS TO PATIENTS: PLEASE REVIEW, CORRECT OR COMPLETE THE INFORMATION ON THE PATIENT INFORMATION FORM AND SIGN THIS SIGNATURE PAGE AS INDICATED. RETURN THE FORM TO US OR BRING IT WITH YOU TO YOUR APPOINTMENT. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE WITH ANY ITEMS, PLEASE ASK A STAFF MEMBER. THANK YOU!