COASTAL EYE INSTITUTE

New Patient Information Form

Chart #

Name: First	Middle	Last	Today's Date:

Drivers License # / State			Patient Social Security #	
Home Phone:			Patient Birth Date:	Age:
Work Phone:			Circle one: MALE FEMALE	
Cell/Other Phone:			Employer/Occupation	
Local Mailing Address:		Apt/Lot#	Emergency Contact:	
City:	State:	Zip:	Phone:	
Out of Town / Other Address:		Apt/Lot#	Relationship to Patient:	
City:	State:	Zip:	Spouse Name:	

PRIMARY Insurance Company:		
Policy Holder's Name:		Policy Holder's Date of Birth:
ID/Policy#:	Group#:	Policy Holder's Social Security #:
Relationship of patient to Policy Holder:		Policy Holder's Employer/Phone:
SECONDARY Insurance Company:		
Policy Holder's Name:		Policy Holder's Date of Birth:
ID/Policy#:	Group#:	Policy Holder's Social Security #:
Relationship of patient to Policy Holder:		Policy Holder's Employer/Phone:

Do you have an Optometrist? Yes No

Dr. ______________________________

Date of last examination: ______________________________

E-mail Address

May we e-mail you? (circle one)

YES NO

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AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, authorize the release of my medical information to my insurance company and the assignment of benefits from my insurance company to Coastal Eye Institute.

Parent/Patient/Guardian Signature: ______________________________

Date: ______________________________

PATIENT RESPONSIBILITY FOR PAYMENTS: In being accepted as a patient of Coastal Eye Institute, I realize I am responsible for all charges incurred. Payment is due at time of services rendered (unless prior arrangements are made in writing). I understand that Coastal Eye Institute will file my insurance for me, but I am responsible for deductibles, co-payments, uncovered services, refractions, and claims denied by my insurance company.

Parent/Patient/Guardian Signature: ______________________________

Date: ______________________________

NOTICE OF PRIVACY PRACTICES: I have received a copy of the Notice of Privacy Practices that describes how my health information is used and shared. I understand Coastal Eye Institute has the right to change this notice at any time. I may obtain a current copy by contacting the doctor's office or by visiting their website at: www.CoastalEye.com.

Parent/Patient/Guardian Signature: ______________________________

Date: ______________________________