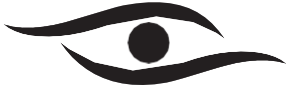

COASTAL EYE INSTITUTE

Patient Information Form

Chart #

NAME **First**	**Middle**	**Last**	Today's Date

Cell Phone ___________________________ May we text you? (circle one) YES NO			Patient Social Security #	
Home Phone			Patient Birth Date / /	Age
Work Phone			Circle one MALE FEMALE	
Email Address: ______________________________ May we email you? (circle one) YES NO			Occupation __________________________ How did you hear about us? ______________	
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 Work 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 Work Phone

TREATMENT CONSENT, PATIENT RESPONSIBILITIES & INFORMATION RELEASE AUTHORIZATION

I give permission to Coastal Eye Institute to provide medical treatment for me/my child.

I allow Coastal Eye Institute to file for insurance benefits to pay for the care received.
Coastal Eye Institute may send medical information to my/my child's insurance company and their subsidiaries.

Assignment of benefits will be made from my insurance companies to Coastal Eye Institute.

I must pay for my/my child's share of costs including deductibles, copayments, refraction fee and any non-covered services.

I must pay the entire cost of services if active insurance coverage is not in place or if the insurance company does not pay.

I understand that payment is due at the time services are rendered.

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 may change this notice at any time. I may obtain a current copy of the privacy notice by contacting Coastal Eye Institute or by visiting their website at CoastalEye.com.

I understand that Coastal Eye Institute will leave phone messages regarding test results, appointment times and other information on my home and cell phone. If I disagree, I will notify Coastal Eye Institute.

I understand and agree to all of the above:

Patient/Parent/Legal Guardian Signature___________________________ Date: ____/____/_____

If the patient is a minor (under the age of 18) or not legally responsible, please state:

Responsible Party: (Print Name) _____________________________________

Relationship to Patient: _____________________________________

Responsible Party's Date of Birth: ____/_____/______

Address of responsible Party:

____

____

City______________________________ State____________ Zip ___________