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### PATIENT REGISTRATION SHEET

PATIENT NAME: \_\_\_\_\_  MALE  FEMALE

PARENT OR GUARDIAN NAME IF UNDER 18: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_\_\_

SINGLE  MARRIED  DIVORCED  WIDOW/WIDOWER  OTHER

MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

**YOUR CONTACT PREFERENCE**  HOME  WORK  CELL  MAIL  E-MAIL

#### HOW DID YOU HEAR ABOUT US?

ADVERTISING  PRIMARY CARE PHYSICIAN  SPECIALIST PHYSICIAN  WORD OF MOUTH  
 PATIENT IN OUR PRACTICE  HOSPITAL  INSURANCE COMPANY  OTHER \_\_\_\_\_

ALTERNATE CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

Check here to give Coastal Eye Care staff permission to speak with your alternate contact regarding health issues.

PATIENT'S EMPLOYER: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

FAMILY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRED BY DR: \_\_\_\_\_

#### RELEASE OF INFORMATION

I hereby authorize release of information to Medicare and request that payment of Medicare benefits be made on my behalf to Coastal Eye Care, P.A., for any covered services furnished to me by the providers at Coastal Eye Care, P.A.

For all other insurances, I authorize Coastal Eye Care, P.A., to release medical information needed by my insurance company for the purpose of providing medical and surgical eye care services.

I hereby acknowledge the receipt of the Notice of Privacy Practices given to me.

#### PLEASE SIGN ONCE.

TODAY'S DATE		PATIENT'S SIGNATURE	
		<i>(or Responsible Party/Sponsor)</i>	
DATE		PATIENT'S SIGNATURE	
DATE		PATIENT'S SIGNATURE	
DATE		PATIENT'S SIGNATURE	