Isaac J. Rudloe, MD
Julie Goldman, MD

PATIENT REGISTRATION SHEET

PATIENT NAME: _____**LEGAL SEX** ☐ **MALE** ☐ **FEMALE**

PATIENT'S PREFERRED NAME: _____**PREFERRED GENDER IDENTITY**_____

PARENT OR GUARDIAN'S NAME IF PATIENT IS UNDER 18: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER**: _____

☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOW/WIDOWER** ☐ **OTHER**

MAILING ADDRESS: _____**CITY:** _____ **STATE:** ____ **ZIP:** _____

☐ **HOME#**_____ ☐**WORK:** _____

☐**CELL#** _____ ☐ **E-MAIL**: _____

***** CHECK YOUR PREFERRED MEANS OF CONTACT – *PLEASE CHECK ONLY ONE* *****

WHAT PHARMACY DO YOU USE? _____ **IN WHAT TOWN?** _____

FAMILY PHYSICIAN: _____ **PHONE**: _____

IF NOT ALREADY AN ESTABLISHED PATIENT, HOW DID YOU HEAR ABOUT US?

_____

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, for any covered services furnished to me by the providers at Coastal Eye Care. For all other insurances, I authorize Coastal Eye Care, to release medical information needed by my insurance company for the purpose of providing medical and surgical eye care services.

I understand that a copy of the Notice of Privacy Practices is available upon request. The Notice of Privacy Practice is posted in the waiting room.

I hereby acknowledge that I have reviewed both sides and updated all information.

TODAY'S DATE_____ **PATIENT'S SIGNATURE** _____

(Or responsible party)