WELCOME TO SHORELINE OPTOMETRY

Name:
_____
_____ Gender: ☐ M or ☐ F
Social Security # (last 4 digits): _____ DOB: ____ / ____ / ____ E-Mail:
_____
Address:
_____
_____
Contact # (Please check preferred number): Okay for text communication? ☐ Yes ☐ No
☐ Home Phone: _____ ☐ Work Phone: _____ ☐ Cell Phone: _____
Occupation: _____ Employer:
_____
Emergency Contact: _____ Contact Phone:
_____
Vision Insurance: ☐ VSP ☐_____ Medical Insurance:
_____
Insured Member: ☐ self ☐_____ DOB: ____/ ____/____ Last 4 # SSN: _____

Relationship to Insured: ☐ spouse ☐ child ☐ domestic partner

RESPONSIBLE PARTY (for billing purposes): ☐ self ☐ parent /guardian ☐ spouse / domestic partner

Name (if other than self): _____

Phone: _____

Address:
_____

I authorize the release of any medical or other information necessary to process my insurance claims. I authorize payment of medical or
vision benefits either to Shoreline Optometry or to myself if my insurance is not accepted for assignment. I understand that I am responsible
for any balance my insurance does not cover.

_____ _____
Signature Date