

WELCOME TO SHORELINE OPTOMETRY

Name: _____ Gender: M or F

Social Security # (last 4 digits): _____ DOB: ___ / ___ / ___ E-Mail: _____

Address: _____

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