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

ACKNOWLEDGEMENT OF HIPAA NOTICES

I hereby acknowledge receipt of the HIPAA Notice of Privacy Practices from Shoreline Optometry.

_____ _____
SIGNATURE DATE

_____
PRINTED NAME

If not signed by the patient, please indicate your relationship to the patient: _____