Coastal Eye Specialists
(805) 983-0700

Date: ____________

PATIENT INFORMATION

Salutation	Patient's Last Name	First Name	MI	Our Acct #

Social Security Number	Date of Birth	Sex	Marital Status

Home Street	City	State	Zip
Work Street	City	State	Zip

Home Phone	Work Phone	Cell

Other Phone [ ]cell [ ]pager [ ]back line	e-mail
Occupation	Employer
Primary Medical Doctor	Regular Optometrist or Optician (if any)

Who referred you to our office, or why did you choose to see us (check all that apply)? [ ]doctor [ ]family member [ ]friend [ ]insurance
[ ]internet [ ]Yellow Pages [ ]advertisement [ ]general reputation. *Please specify: :*

Who should we call in an emergency?	Phone Number	Relationship to patient

Primary Insurance	Group Number	Policy Number
Name of Policy Holder	Relationship to Patient [ ]self [ ]spouse [ ]parent [ ]other	
Secondary Insurance	Group Number	Policy Number
Name of Policy Holder	Relationship to Patient [ ]self [ ]spouse [ ]parent [ ]other	
Vision Plan, if any (for glasses/routine eye care)	Group Number	Policy Number
Name of Policy Holder	Relationship to Patient [ ]self [ ]spouse [ ]parent [ ]other	

RESPONSIBLE PARTY (GUARANTOR OR INSURANCE SUBSCRIBER) INFORMATION

	Responsible Party's Last Name	First Name	MI	

Social Security Number	Date of Birth	Relationship to Patient [ ]spouse [ ]parent [ ]other

Home Street	City	State	Zip
Work Street	City	State	Zip

Home Phone	Work Phone	Cell

Occupation	Employer

Coastal Eye Specialists
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Date: ____________

Name: ____________________________ **Account Number:** ____________

PATIENT SIGNATURE PAGE

CONSENT TO EXAMINATION AND TREATMENT: I understand that the examination or treatment performed by the doctor may include dilation of the eyes and other procedures that may affect my vision. I understand that I may be temporarily impaired for driving, reading, the operation of machinery, and other tasks. I agree to make arrangements for my own transportation if needed. I agree to drive only if I believe my vision is adequate, and do so at my own risk and responsibility. If I do not wish to have my eyes dilated, I understand that it is my responsibility to notify the doctor and his/her assistants before drops are instilled, and that this may limit the completeness and extent of my examination and treatment.

ASSIGNMENT OF INSURANCE BENEFITS AND RELEASE OF INFORMATION: If I do not pay for services rendered myself, I authorize the payment of my insurance benefits directly to Coastal Eye Specialists Medical Group, Inc. I understand that, while my insurance may assist me in paying for my medical expenses, I am financially responsible for the services provided to me. This includes payment for any copayments, deductibles, and services that are not covered by insurance.

FOR MINOR OR INCAPACITATED PATIENTS ONLY: If the patient is a minor or has been deemed incapacitated, I certify that I am a responsible parent/guardian/conservator for the patient, and hereby consent to the examination and treatment of the patient as judged necessary and advisable by the doctor.

We are required by law to maintain the privacy of protected health information and to provide patients with our Notice of Privacy Practices, which describes how we may use and disclose your health information, your rights, and our legal obligations regarding this information. This Notice is posted in the reception area and on our web site (www.coastaleye.net). A copy is available for you to keep on request.

PRIVACY NOTICE: I acknowledge that I have been provided a Notice of Privacy Practices.

Signed: ____ **Date:** ____________

Print name: ____

If not signed by the patient, please relationship: ________________________________

INSTRUCTIONS TO PATIENTS: *PLEASE REVIEW, CORRECT OR COMPLETE THE INFORMATION ON THE PATIENT INFORMATION FORM AND SIGN THIS SIGNATURE PAGE AS INDICATED. RETURN THE FORM TO US OR BRING IT WITH YOU TO YOUR APPOINTMENT. IF YOU HAVE ANY QUESTIONS OR NEED ASSISTANCE WITH ANY ITEMS, PLEASE ASK A STAFF MEMBER. THANK YOU!*