PATIENT INFORMATION

Date: ______________________

PLEASE PRINT CLEARLY

NAME: Last: ________________ **First:** ______________ **Middle Initial:** _____ **Maiden:** ______________

Address: Street: ____

City: ______________________________________ State: _________ Zip Code: __________

Home Phone #: ____________________________ Marital Status: MARRIED / SINGLE / DIVORCED / WIDOWED

Cell Phone #: ____________________________ Email: ______________________________

Age: ______ Date of Birth: ________________ Sex: (M) (F) Social Security#: ________________

Patient's Occupation: ____________________________________ Employer: ____________________

Patient's Employer's Address: ________________________________ Employer's Tel. #: ____________

Name of Patient's Primary Care Physician: ____

Spouse's Name: ____

Insurance Policy Holder's Information:

Name: ____

DOB: ____

Relationship to Patient: ___________________ Gender: ___________________

Social Security #: ____

Spouse's Place of Employment: ____

Address: ____ Phone ______________

Whom may we thank for referring you to the office?

Name: ____________________________________

Address: __________________________________

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Do you currently have an optometrist? Yes ☐ No ☐

Name: ____________________________________

Last time seen: ____________________________

Person not currently living with you that we may contact in case of emergency:

Name: ____

Relationship: ____

Phone #: ____

Reason for Visit: ____

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Lifetime Insurance Authorization and Release of Medical Information:

I request that payment of the authorized health insurance benefits (e.g.: Medicare, Medicaid, Medex, Blue Shield, Workman's Compensation, Commercial, etc.) be made to me or on my behalf to Southcoast Eye Care, Inc., Southcoast Optical Shop, Inc. and it's physicians, for any services furnished by the physicians and staff employed there. I authorize any holder of medical information about me to release to my insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services.

Once the physicians at Southcoast Eye Care, Inc., Southcoast Optical Shop, Inc. have obtained my one time authorization, they may submit any later insurance claims on either an assigned or non-assigned basis, without obtaining any additional signature from me. In submitting claims, they should indicate in the patient's signature space: "Signature on File."

______________________ ____

Date Patient Signature

When you return this form to the receptionist, please have all your insurance cards available to be photocopied. THANK YOU!