WELCOME TO COASTAL EYE CARE

Patient Information

First Name _____ Last Name _____ M.I. _____

Mailing Address _____ Date of Birth _____

City _____ State _____ Zip code _____

Patient SSN _____ Sex M or F Home Phone _____

Work Phone _____ Cell Phone _____ Ok to text? Y or N

Email _____ Employer _____

Occupation _____ Marital Status ☐ Single ☐ Married ☐ Other

Guardian Information

First Name _____ Last Name _____ M.I. _____

Date of Birth _____ Guardian SSN _____ Sex M or F

Address if different _____ Relationship to Patient _____

Insurance Information ☐ Self ☐ Spouse ☐ Parent ☐ Other

Policy Holder First Name _____ Last Name _____ M. I. _____

Date of Birth _____ SSN _____ Sex M or F

Insurance _____ Insurance ID Number _____

Emergency Contact :

Name _____ Phone _____ Relationship _____

Please read the following below:

- We will bill your insurance courtesy to you. However, you are still responsible for your account.
- We will not bill any insurance for less then $30.00. A statement will be provided so that you may submit it for reimbursement.
- If your insurance does not pay or pays less than expected, it is your responsibility.
- A service charge of 1% per month will be imposed on all accounts 30 days past due.
- If collection actions are necessary, you will be responsible for all costs of collection and/or attorney fees in addition to the amount owed.
- A minimum of $25.00 fee will be assessed for any NSF checks.
- ASSIGNMENT and RELEASE: I request that payment from my insurance company, if applicable, be made on my behalf to my providing doctor. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Signature(Responsible Party) _____ Date _____