Patient Name: _____ Nickname: _____

Date of Birth: _____ SS:_____ Marital Status:_____ M___ F___

Address: _____ Apt #:_____

City: _____State: _____Zip:_____ Email Address: _____

Home Phone: _____ Cell Phone: _____ DL#: _____

Employer: _____ Occupation: _____

Primary Physician: _____ Phone: _____

How did you hear about us? _____ Are you Diabetic?:_____ Interested in Lasik?:_____

Do you have any history of Glaucoma, Cataracts, or retina disorders?_____

Please provide the Insurance Policy Holder Information:

Name: _____ Date of Birth: _____ SSN: _____

Phone: _____ Employer: _____

Address: (If different from above) _____

Vision Insurance: _____ Policyholder Name: _____Relationship_____

Primary Medical Insurance: _____ Policyholder Name: _____Relationship_____

Secondary Medical Insurance: _____ Policyholder Name: _____Relationship_____

I authorize Atlantic Eye Associates to release my medical and/or billing information to the following individual/s.

1. _____Relation to Patient:_____
2. _____Relation to Patient:_____
3. _____Relation to Patient:_____

I acknowledge available paper copies at my request and/or link to www.atlanticeyes.com for a complete HIPPA Privacy Agreement for Atlantic Eye Associates.

Due to the recent and unpredictable changes within the insurance industry, Atlantic Eye Associates is requesting all patients to verify and be familiar with their insurance benefits prior to being seen in our office. As a courtesy, our staff will continue to verify and bill your insurance, but we cannot guarantee coverage or that the information we have received from your carrier and conveyed to you is accurate or complete. Please read and print your electronic signature that you have received and understand the following:
I understand that Atlantic Eye Associates will bill most insurance carriers and that all co-pay and deductible amounts are expected to be paid at the time of my appointment unless other arrangements have been made in advance. Should I have a balance for any reason after my insurance has processed the bill, a statement will be sent to me. It will be my financial responsibility to pay this balance due.

Electronic Printed Name: _____ *Date:*_____

Clear Form