COASTAL EYE CENTER /Paul D. Pare', M.D., FACS/David Jones, MD, PhD
1000 SE FEDERAL HWY, Suite 200, STUART FL 34994

Date: _____

How did you hear about us? Circle one

Website **Advertisement**

Friend _____

Doctor_____

Name: _____
Last **First** **M.I.**

Date of Birth: _____Age:_____ SS #_____

Marital Status: _____ Spouse's Name_____

Language: (circle one)	**Race: (circle one)**	**Ethnicity: (circle one)**
English	**White**	**Hispanic Origin**
Spanish	**Black/African American**	**Not of Hispanic Origin**
Other _____	**Asian or Pacific Islander**	
	American Indian or Alaskan Native	

LOCAL Address: _____
Street **Unit/Apt #**

_____
City **State** **Zip Code**

OTHER Address: _____
Street **Unit/Apt #**

_____
City **State** **Zip Code**

Home Phone: _____Cell Phone: _____

Work Phone: _____ Email: _____

Employer: _____Occupation: _____

Employer Address: _____
Street **Suite**

_____
City **State** **Zip Code**

Local Pharmacy Name: _____

Pharmacy Location: _____

Pharmacy Phone#: _____

Pharmacy mail order: _____

Emergency Contact Name: _____Emergency Phone: _____

Name & Address of RESPONSIBLE PARTY (If other than patient)

Name: _____ Phone: _____

Address: _____
Street **Unit/Apt #**

_____
City **State** **Zip Code**

Insurance Information: _____ _____
Primary **Secondary**

Please complete the information below if you are NOT the primary policy holder on your insurance.

Policy Holder's Name: _____ DOB: _____ Soc. Sec. #: _____

I authorize any holder of medical or other information about me to be released to the Social Security Administration, Health Care Financing Administration or its intermediaries or carriers, any other insurance carrier, or to the billing agent of this supplier, any information needed for this or a related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

***I hereby acknowledge responsibility for payment in full, in the case, that my primary and/or secondary insurance company fails to pay any or all of my claims. In the event that I am found or known to be without insurance, I acknowledge that I will be responsible for payment in full at time of services rendered.**

I permit the use of this signature for the entire length of my association with Coastal Eye Center, Paul D. Pare', M.D., or until such time as all benefits due to Coastal Eye Center are paid in full. By signing below I verify that all the information I provide is accurate and valid.

Please be aware, a charge will be made for broken appointments, unless 24 hour notice is given.

_____ **_____**
Patient Signature **Parent or GuardianSignature**