Lawrence Piazza, M.D.
Walter N. Muth, M.D.
Isaac J. Rudloe, M.D.

128 Bucksport Road
Ellsworth, Maine 04605
207-667-6300
http://www.coastaleyecare.net

PATIENT REGISTRATION SHEET

PATIENT NAME: _____ ☐ **MALE** ☐ **FEMALE**

PATIENT'S PREFERRED NAME OR NICKNAME: _____

PARENT OR GUARDIAN'S NAME IF PATIENT IS UNDER 18: _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER**: _____

☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOW/WIDOWER** ☐ **OTHER**

MAILING ADDRESS: _____**CITY:** _____ **STATE:** ____ **ZIP:** _____

***** CHECK YOUR PREFERRED MEANS OF CONTACT – *PLEASE CHECK ONLY ONE* *****

☐ **HOME**: _____ ☐**WORK:** _____

☐**CELL**: _____ ☐ **E-MAIL**: _____

ALTERNATE CONTACT NAME _____**PHONE NUMBER** _____

RELATIONSHIP: ☐ **SPOUSE** ☐ **PARENT** ☐ **FRIEND** ☐ **CHILD** ☐ **SIBLING** ☐ **OTHER** _____

☐ Check here to give Coastal Eye Care staff permission to speak with your alternate contact regarding health issues

WHAT PHARMACY DO YOU USE? _____ **IN WHAT TOWN?** _____

WOULD YOU LIKE TO ACCESS YOUR DIAGNOSIS INFORMATION VIA THE INTERNET? YES NO

FAMILY PHYSICIAN: _____ **PHONE**: _____

REFERRED BY DR: _____

RELEASE OF INFORMATION

I hereby authorize release of information to Medicare and request that payment of Medicare benefits be made on my behalf to Coastal Eye Care, P.A., for any covered services furnished to me by the providers at Coastal Eye Care, P.A.

For all other insurances, I authorize Coastal Eye Care, P.A., to release medical information needed by my insurance company for the purpose of providing medical and surgical eye care services.

I hereby acknowledge the receipt of the Notice of Privacy Practices given to me.

**** PLEASE SIGN AND DATE ONLY ONCE ****

TODAY'S DATE _____ **PATIENT'S SIGNATURE** _____

(or Responsible Party/Sponsor)

UPDATES: I hereby acknowledge that I have reviewed both sides and updated all information.

DATE _____ **PATIENT'S SIGNATURE** _____

DATE _____ **PATIENT'S SIGNATURE** _____

DATE _____ **PATIENT'S SIGNATURE** _____