

EYE ASSOCIATES, P.C.
PATIENT REGISTRATION

ACCOUNT NUMBER _____ INSURANCE INFORMATION:

DATE _____ NAME OF SUBSCRIBER _____

LAST NAME: _____ PATIENT SOCIAL SECURITY # _____

FIRST NAME: _____ **IN CASE OF EMERGENCY PLEASE NOTIFY:**

MIDDLE: _____ NAME: _____

ADDRESS: _____ ADDRESS: _____

CITY/TOWN/ST/ZIP: _____ PHONE: _____

PHONE (HOME): _____

PHONE (CELL): _____ SIGNATURE FOR ASSIGNMENT OF INSURANCE BENEFITS

EMAIL ADDRESS: _____

DATE OF BIRTH: _____

PLEASE CIRCLE: MALE FEMALE

PRIMARY CARE: _____

SPECIALIST: _____

ADDRESS: _____

PHONE NUMBER: _____

RESPONSIBLE PARTY

NAME: _____
(OTHER THAN PATIENT)

ADDRESS: _____
(IF DIFFERENT FROM PATIENT)

PATIENT OCCUPATION: _____

NAME OF COMPANY: _____

ADDRESS: _____

EMPLOYER PHONE NUMBER: _____

We are required to ask for Ethnic origin and language; you are not obligated to answer:

LANGUAGE: circle

ARABIC	CANTONESE	CHINESE	ENGLISH
FRENCH	GERMAN	GREEK	GUJARATI
HINDI	ITALIAN	JAPANESE	KOREAN
MANDARIN	PORTUGUESE	RUSSIAN	SPANISH
TAGALO	VIETNAMESE		

PATIENT DECLINED: _____

RACE: circle

ALASKA NATIVE AMERICAN INDIAN
ASIAN BLACK OR AFRICAN AMERICAN
NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
WHITE/CAUCASIAN

PATIENT DECLINED: _____

UNKNOWN: _____

ETHNICITY: circle

HISPANIC NON HISPANIC UNKNOWN

EYE ASSOCIATES, P.C.

PATIENTS NAME: _____
EXTENDED HISTORY: _____

DATE OF LAST PHYSICAL: _____

MEDICATIONS: NO MEDICATIONS

If any, please list all medications that you are taken with specific name and dosage:

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO
IF YES, PLEASE LIST: _____

DATE OF LAST EYE EXAM: _____

DO YOU WEAR GLASSES? YES NO

DO YOU WEAR CONTACT LENS? YES NO

HAVE YOU EVER HAD MAJOR EYE SURGERY, MAJOR ILLNESS OR HOSPITALIZATION? YES NO
IF YES, PLEASE EXPLAIN: _____

IS THERE ANY HISTORY IN YOUR FAMILY OF:

- | | | | | |
|--------------------------|-----|--------------------------|----|------------------------------|
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | GLAUCOMA |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | CATARACTS |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | LAZY EYE OR MUSCLE IMBALANCE |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | RETINAL DISEASE |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | OTHER |

HAVE YOU EVER HAD:

- | | | | | |
|--------------------------|-----|--------------------------|----|---------------|
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | EYE INJURY |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | EYE INFECTION |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | EYE SURGERY |

HAVE YOU NOW OR EVER HAD PROBLEMS WITH:

- | | | | | | | |
|--------------------------|--------|--------------------------|-----|-------------------------------|----|------|
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | DIABETES MELLITUS (ENDOCRINE) | | |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | HIGH BLOOD PRESSURE/HEART | | |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | EAR, NOSE, THROAT | | |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | LUNGS | | |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | KIDNEYS | | |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | MUSCLE | | |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | STOMACH OR INTESTINES | | |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | ARTHRITIS | | |
| <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | NEUROLOGIC | | |
| <input type="checkbox"/> | OTHER: | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO | SKIN |

Patient Name: _____ DOB: _____ MR: _____

PATIENT AUTHORIZATION TO SHARE HEALTHCARE INFORMATION

I authorize Eye Associates to share my Medical information to the following individuals:

1. Name: _____ Address: _____

Phone Number: _____ Relationship to patient: _____

Expiration date: _____

2. Name: _____ Address: _____

Phone Number: _____ Relationship to patient: _____

Expiration date: _____

Please list any restriction of disclosure below:

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the **Federal HIPAA Privacy Act**. I have rights to revoke this authorization in writing except to the extent that the covered entity has acted in reliance upon the authorization.

My written revocation must be submitted to the Privacy Officer at the covered entity.

FINANCIAL POLICY RESPONSIBILITY

Should I receive a bill requesting payment for services rendered I accept full responsibility for payment in full.

Account Number: _____ **Office will complete account number**

LEAVING VOICE MAIL MESSAGE

I, _____ authorize Eye Associates to leave a voice mail message on my cell/home phone number _____ informing me of an appointment, test results, rescheduling, or other information pertaining to my eye care.

ACKNOWLEDGEMENT OF HIPAA

I hereby acknowledge that I have been given the opportunity to read the Notice of Privacy Practices

SIGNATURE OF PATIENT _____ **DATE:** _____