Patient Registration Form

Please provide your Driver's License and Insurance Cards to front receptionist.

Name (Last , First , MI) : _____

Address (if different than on driver's license) : _____

Home Telephone : _____

Cell Phone: _____

Email: _____

Primary Care Physician: _____

Emergency Contact Person's Name / Tel _____

Lifetime Insurance Authorization:

I authorize and request that payments under my medical insurance programs be made directly to pay provider for any services furnished to me. I also authorize the provider to release any information needed for the payment of claims. I further permit copies of this authorization to be used in place of the original.

Patient Signature: _____ Date _____

Financial Agreement:

I acknowledge full responsibility for all charges incurred, including any additional charges incurred in the collection of my amount. I can elect to pay all charges myself, even if I have insurance. If I use my insurance, I will nevertheless remain fully responsible for all charges, including any additional charges incurred if my insurance determines my services to be noncovered, only partially covered, or not a benefit.

Patient Signature: _____ Date _____

Privacy Policy (HIPAA):

I understand that HIPAA has implemented procedures that require specific authorization for release of my information. I agree to the following statements and understand that I may revoke these at any time by informing the Privacy Officer in writing.

Home Telephone Number: We may leave a message with a callback number or appointment on voicemail.
Written Communication: We may mail postcards to your home address or send you an email
I have received the NOTICE OF PRIVACY PRACTICES and I have been provided an opportunity to review it.

Patient Signature: _____ Date _____

MEDICAL HEALTH QUESTIONNAIRE

Name : (Last/first/initial) _____ Today's Date: _____

Date of Birth: _____/_____/_____

Medications: _____

_____

ALLERGY to medications /latex /iodine ? No / Yes : State drug and reaction:_____

List all Medical Conditions (Diabetes, High Blood Pressure, Heart Disease , COPD , Asthma) :

_____

List any surgeries (including eye surgeries) : _____

Do you currently have any problems in the following areas? If YES, please circle all that apply & write any additional

	YES	NO	Details
GENERAL (fever, weight loss or gain, lethargy)			
EARS, NOSE, THROAT (Hearing loss , nasal congestion, cough, dry mouth)			
RESPIRATORY (Congestion, wheezing, short of breath, asthma, COPD)			
CARDIOVASCULAR (High blood pressure, abnormally fast or slow heart rate, chest pain, heart attack)			
GASTROINTESTINAL (Diarrhea, constipation, GERD ulcers)			
GENITAL, KIDNEY, BLADDER (Painful urination, frequent urination, impotence, kidney stones)			
SKIN (Skin cancer, rash, hives)			
ENDOCRINE (Diabetes Type 1 or Type 2, Hypothyroidism)			
NEUROLOGICAL (Numbness, headache, seizures, paralysis, stroke)			
MUSCLES, BONES, JOINTS (Joint pain, stiffness, swelling, cramps, arthritis)			
BLOOD/LYMPH (Bleeding or Clotting disorders, deep vein thrombosis, pulmonary embolism)			
ALLERGIC/IMMUNOLOGIC (Sneezing, swelling, redness, itching, hives, lupus)			

Do you smoke? Yes / Never / Previous smoker ____ packs per day

Family History of Glaucoma / Macular Degeneration/ Retinal Detachment ? No / Yes:Whom? _____