PATIENT REGISTRATION

PATIENT'S NAME:	Soc. Sec. #:	Sex: M F	Birthdate:	Age:
Address: City State Zip			Home Phone:	
EMAIL ADDRESS:	If child: Indicate name of parent(s) or guardian:		Cell Phone:	
Name of Employer:	Your Occupation:		Work Phone:	
Do you have Health Insurance? ☐ YES ☐ NO	Do you have a Vision Plan? ☐ YES ☐ NO	**PRESENT CARD(S) TO RECEPTIONIST**		

YOUR PHARMACY INFORMATION

Name:	Address:		
City:	State:	Zip:	Phone:

The following information is being collected per Federal Government regulation in the Health Information Technology Act (HITECH ACT). Your response is optional.

Communication Preference:
☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email ☐ Text

Primary Language:
☐ English ☐ Spanish ☐ French ☐ Patient Declined to Answer

Ethnicity:
☐ Unknown ☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Patient Declined to Answer

Race:
☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander

☐ White ☐ Other Race ☐ Patient Declined to Answer

RELEASE AUTHORIZATION FOR MEDICAL OR FINANCIAL INFORMATION

Do you give authorization to discuss medical and financial information with your spouse or other specified person? ☐ YES ☐ NO
Names:

Have you appointed a Power of Attorney/Healthcare Surrogate to make medical or financial decisions on your behalf? ☐ YES ☐ NO
If YES: Name: Relationship: Phone Number:

IN CASE OF EMERGENCY: Name of friend / relative NOT residing with you:	Relationship:	Phone Number:

FAMILY PHYSICIAN	**Whom may we thank for referring you to this office?** Physician ______ Patient ______ Other ______

GENERAL HISTORY	Yes	No
Diabetes		
High Blood Pressure		
Heart Problems		
Kidney Problems		
Thyroid Problems		
Arthritis		
Breathing Problems		
Stroke / TIA		
Cancer		
Smoke		
Drink		
Other:		

EYE HISTORY	Yes	No	Family
Glaucoma			
Macular Deg.			
Cataract			
Eye Injury			
Lazy Eye			
Eye Surgery			
Dry Eyes			
Contact Lens Wearer			
Other:			

VISUAL PROBLEMS	Yes	No
Blurry Vision		
Double Vision		
Light Flashes / Floaters		
Burning / Itching / Tearing		
Headaches		
Redness		
Eye Pain		
Other:		

Please list all DRUG ALLERGIES:

Current Medications: (if available, present list to receptionist)

Reason for today's visit? (Be specific)

LIFETIME AUTHORIZATION

I authorize reports of my evaluation, treatments and any follow up evaluations to be sent to my referring doctor, the doctor requesting consultation, my family physician, as well as any other health care providers, hospitals or outpatient facilities that have or will identify to you.

Elmquist Eye Group may use & disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Refer to our "Notice of Privacy Practices". We reserve the right to revise such notice at any time. Elmquist Eye Group may call or mail to my home or other designated location and leave a message on voice mail or in person in reference to any items that assist them in carrying out my TPO such as appointment reminders, insurance items including patient statements and any information pertaining to my clinical care.

I authorize any holder of medical or other information about me, to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, or to the billing agents of my insurance companies or to my employer if it is a workmen's compensation claim, any information needed for this or a related insurance or Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to myself or to the party who accepts assignment. If I have been tested for or have contracted Autoimmune Deficiency syndrome (AIDS) / Human Immunodeficiency virus (HIV), I authorize the release of the fact and/or results of testing to any of the individuals, health care providers or third party payors related to my care. (Trevor Elmquist, D.O. does not provide or perform testing for the virus.)

I understand that I am fully and legally responsible for all billing charges of this account which includes all outstanding balances not covered by Medicare and/or insurance companies. In the event that I fail to pay any outstanding balance, I also agree to pay all costs of collection agency fees, and court costs, if any.

GUARANTOR SIGNATURE:____________________________ DATE:________________

STAFF USE ONLY:

Pt ID verified: _________ **Ref form:** _________ **HIPPA:** _________