☐ Richard A. Burgett, M.D., F.A.C.S.
☐ Thomas A. Ciulla, M.D.
☐ Robert D. Deitch, M.D.
☐ Neil P. Finnen, M.D.
☐ Kathryn M. Haider, M.D.
☐ Scott R. Hobson, M.D., F.A.C.S.
☐ Frank N. Hrisomalos, M.D.
☐ Nicholas F. Hrisomalos, M.D.
☐ Stephen M. Johnson, M.D.
☐ Kevin E. Lai, M.D.
☐ Ronald T. Martin, M.D., F.A.C.S.

# PATIENT REGISTRATION

MIDWEST EYE INSTITUTE
ESTABLISHED 1982

☐ Raj K. Maturi, M.D.
☐ John T. Minturn, M.D.
☐ Daniel E. Neely, M.D.
☐ Hemang C. Patel, M.D.
☐ David A. Plager, M.D.
☐ Gavin J. Roberts, M.D.
☐ Milan Shah, M.D.
☐ Clark L. Springs, M.D.
☐ Derek T. Sprunger, M.D.
☐ Robert M. Troyer, M.D.
☐ Michael G. Welsh, M.D., F.A.C.S.

## PATIENT INFORMATION

Name: _____ Date: _____
Last First Middle

Date of Birth:_____ Age: _____ Gender: ☐ M ☐ F Social Security #:_____
mm/dd/yyyy xxx-xx-xxxx

Address: _____Apt #: _____City: _____State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Mobile: (_____) _____

Email Address: _____

Preferred Method of Phone Contact: ☐ Mobile ☐ Home ☐ Work (please check one)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Minor Child

Spouse's Name: _____ Date of Birth: _____ Social Security #: _____
mm/dd/yyyy xxx-xx-xxxx

Spouse's Employer: _____ Address: _____ Phone #:(_____) _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to answer

Race: ☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other Race
☐ Decline to answer

*If patient is a minor, lives with:* _____ *Relationship:* _____

Student Status: ☐ Full-Time ☐ Part-Time ☐ Not-a-Student

School Name: _____ Address: _____City: _____State: ____ Zip: _____

**PATIENT OR PARENT / LEGAL GUARDIAN**

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not-Employed

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

**Patient Name:** _____ **Date:** _____

## EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address (if different from patient): _____City: _____State: _____ Zip: _____

Primary Phone #: (_____) _____ Alternate Phone #: (_____) _____

## RESPONSIBLE PARTY: *(if other than patient, please complete)*

Responsible Party: ☐ Guarantor ☐ Self

Responsible Party Name: _____Relationship: _____
Last First Middle

***Check here if address is same as patient*** ☐

Address: _____Apt #: _____City: _____State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____
mm/dd/yyyy xxx-xx-xxxx

Home Phone: (_____) _____ Work Phone: (_____) _____ Mobile: (_____) _____

Employer Name: _____ Address: _____

## REFERRING PHYSICIAN & PHARMACY INFORMATION

Name of Referring Physician: _____ Phone #: (_____) _____

Name of Family/Primary Care Physician: _____ Phone #: (_____) _____

Primary Physician Address: _____ _____City: _____ State: _____ Zip: _____

Preferred Pharmacy Name: _____ Phone #: (_____) _____

Preferred Pharmacy Address: _____ Phone #: (_____) _____

## MEDICAL INSURANCE INFORMATION

Do you have medical insurance to cover your examination or treatment? ☐ Yes ☐ No

*If Yes, we will take a copy of your insurance card(s). If you do not have your insurance card with you, please provide us with your insurance carrier and your I.D. #:* _____

Does your insurance company require a formal authorization or referral from a Primary Care Physician for our services?

☐ Yes ☐ No If Yes, Physician's Name: _____

## ACCIDENT INFORMATION: *(Complete if your treatment is for an injury or accident)*

Were you injured at work? ☐ Yes ☐ No Is this covered by Workman's Compensation? ☐ Yes ☐ No

Contact Person at Your Employer: _____

Date & Time of Accident: _____ Location: _____

How did injury happen? _____

Name of Physician who treated you at the time of accident: _____

**Patient Name:** _____ **Date:** _____

# *PATIENT REGISTRATION CONTINUE*

## RELEASE OF INFORMATION

I authorize the release of any medical information necessary to my insurance company relative to services rendered. I further authorize the Payment of Benefits to the Physician for services rendered. I understand that this authorization remains valid unless/until I revoke it myself.

**X** _____ Date: _____
Signature of Patient or Legal Guardian

## FINANCIAL RESPONSIBILITY STATEMENT

I acknowledge responsibility for payment of all medical fees regardless of insurance I may have to assist me in this responsibility. The only exception will be charges for services covered under a contractual agreement that has been entered into between my physician and an insurance company, or other third party payor. If for any reason my account should become delinquent, I am liable to pay all collection and legal fees.

**X** _____ Date: _____
Signature of Patient or Legal Guardian

## IMAGING RELEASE

I consent that images, including photographs, may be taken in connection with the medical services I receive. I understand that such images shall be retained in my medical record and may need to be shared with others, including but not limited to my insurance carrier. I also give permission for these images and information relative to them and/or relating to my case to be published and republished for the purposes of medical research, education or science. I realize any publication of these images will be "de-identified" so they cannot be recognized as belonging to me specifically. I understand that this release remains valid unless/until I revoke it myself.

**X** _____ Date: _____
Signature of Patient or Legal Guardian

*Note: If these consents are signed by a Legal Guardian, your physician reserves the right to request the Power of Attorney (POA), or other legal document, that assign that right.*