PATIENT REGISTRATION

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MIDWEST EYE INSTITUTE
ESTABLISHED 1982

PATIENT INFORMATION

Name: _____ **Date:** _____
Last First Middle

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

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Home Ph.: (____) _____ Work Ph.: (____) _____ Mobile: (____) _____

Email: _____ ☐ or Text Appointment Notice *(optional)* ☐

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: _____ 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 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

CONSENT FOR BLOOD-BORNE INFECTIOUS DISEASE TESTING

I authorize my physician to test for blood-borne infectious diseases including but not limited to hepatitis, Acquired Immune Deficiency syndrome ("AIDS"), and Human Immunodeficiency Virus ("HIV"), as indicated medically or to protect the health of the care-givers of this organization, as per protocol. The results of these tests will become part of my confidential medical record. Such testing will not be completed unless medically necessary and patient will be advised of the necessity.

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.