PATIENT REGISTRATION

PATIENT'S NAME:	Soc. Sec. #:	Sex:	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 / HSA or HRA/ High Deductible Health Plan / None	PRESENT CARD(S) TO RECEPTIONIST			

YOUR PHARMACY INFORMATION

Name.	Address.
City: State: Zip	Phone

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 a NO
Names.

Do you give authorization to leave medical results on your voicemail or answering machine? a YES NO

Have you appointed a Power of Attorney/Healthcare Surrogate to make medical or financial decisions on your behalf? a 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

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

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

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

Ethnicity:
Unknown Not Hispanic or Latino Hispanic or Latino C) Patient Declined to Answer

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

a White Other Race Patient Declined to Answer

GENERAL HISTORY	Yes	No
Diabetes		
High Blood Pressure		
Heart Problems		
Kidney Problems		
Thyroid Problems		
Arthritis		
Breathing Problems		
Stroke / TIA		
Cancer		
Autoimmune Condition		
Alcohol: Never / Daily / Social		
Smoke: Never / Former / Daily		
Other:		

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

Current Medications: (Present list to receptionist)

Specific reason for today's eye exam

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.

STAFF USE ONLY:

Patient ID verified:________ Refraction form given: ________ HIPAA form given:________

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. (E. Trevor Elmquist, D 0., P.A. (dba) Elmquist Eye Group 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. Due to the additional amount of time and use of office supplies, it is our policy to collect a fee for the completion of various forms and to copy medical records. Form fees range from $10 - $95. Records requests is $1 per page for the first 25 pages. For each page in excess of 25 pages, the cost shall be $0.25.

GUARANTOR SIGNATURE: ________________________ DATE: ________________