PATIENT REGISTRATION FORM

Patient Information

Legal Name _____

Sex: ☐ Male ☐ Female

Primary Doctor _____

Pharmacy _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline

Race: ☐ White Other ☐ _____

Primary Language: ☐ English ☐ _____

Special Needs: ☐ Hearing Impaired ☐ Translator ☐ Wheelchair

SSN _____ - _____ - _____

Date of Birth _____ / _____ / _____

Address _____

City / State _____ / _____

Zip Code _____

Home/Cell Phone _____

Email Address _____

Emergency Contact

Name _____

Relationship to Patient _____

Home/Cell Number _____

Account Responsible Information (if other than patient)

Legal Name _____ Relationship to Patient _____

Sex: ☐ Male ☐ Female

Date of Birth _____ / _____ / _____

Home/Cell Phone _____

SSN _____ - _____ - _____

Address _____

City / Zip _____ / _____

CORRESPONDENCE AUTHORIZATION

Young Vision Care is committed to protecting our patient's privacy. Without authorization, messages left on answering machine, voicemail, or with other individuals will be limited to the caller's name that they are calling for Young Vision Care and the phone number to call. If you prefer that more complete information be provided, please fill out the form below. This authorization will remain valid unless revised by you.

Home/Cell Phone _____

- ☐ Leave message – appointment
- ☐ Leave message – Glasses/Contacts/Medication
- ☐ Leave message – Insurance/Billing
- ☐ Do not leave message of any kind

We also offer the following at your request.

Newsletters: ☐ Yes ☐ No
Promotions: ☐ Yes ☐ No
Fundraising: ☐ Yes ☐ No

If you have authorized us to leave a message, please indicate specifics below:

- ☐ Text message
- ☐ Voicemail / Answering machine only
- ☐ Whoever answers the phone
- ☐ Only the following individual(s):

_____

_____

_____

Any written communication will go to the mailing address on file. Please verify that we have the correct address listed. Billing communication will go to the Account Responsible mailing address.

_____ _____

Signature of Patient or Personal Representative Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given a copy of the Notice of Privacy Practices from Young Vision Care, which describes how my health information is used and shared. I understand that Young Vision Care has the right to change this Notice at any time. I may obtain a current copy by contacting the Financial Coordinator, or by visiting the Office web site at www.youngvisioncare.com.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print name Personal Representative's Title (e.g., Guardian, Executor, etc.)

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements of H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Young Vision Care to release my records and any information to the following individuals.

1. _____ **Relation to Patient:**_____
2. _____ **Relation to Patient:**_____
3. _____ **Relation to Patient:**_____
4. _____ **Relation to Patient:**_____

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print name Personal Representative's Title (e.g., Guardian, Executor, etc.)