

PATIENT REGISTRATION FORM Date of Appointment: PATIENT INFORMATION Last Name: First Name: Middle Name: Patient's Address: Apt #: City: State: Zip Code: Date of Birth: SSN: Sex: □M □F Marital Status: □Single □Married □Divorced □Widowed Language: □English □Spanish □Mandarin □Cantonese Ethnicity: □Asian □Caucasion □African American □Korean □Other: □ Native American □ Hispanic Home Phone: Mobile Phone: Work Phone: Email Address: **Emergency Contact Name: Emergency Contact Phone: Emergency Contact Relation:** Legal Guardian Name (For Children Only): Relationship: How did you hear about us? □Google □Insurance □Internet □Print Ad ☐Friend/Family Name: □Doctor □Other PRIMARY CARE PHYSICIAN Primary Care Physician Name: Primary Care Physician Address: Primary Care Physician Phone: Fax: **PHARMACY** Pharmacy Name: Pharmacy Address: Pharmacy Phone: **BILLING AND INSURANCE Primary Insurance Company:** Plan Name: Plan ID Number: Group Number: Insured's Employer/School: Insured's Name: Relation to Patient: Insured's Phone Number: Insured's SSN: Insured's Birth Date: Secondary Insurance Company: Plan ID Number: Plan Name: Vision Insurance Company: Plan Name: Plan ID Number: Group Number: Insured's Employer/School: Insured's Name: Relation to Patient: Insured's Phone Number:

Insured's Birth Date:

Insured's SSN:

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any of the following	<b>]</b> ?							D	П			
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□Asthma	□ Gout						П	177	П	F7	П	
☐ Asthma ☐ Sleep Apnea	☐Gout ☐Dermatitis	Corneal Disease/Keratoconus										
☐ Sleep Apnea ☐ Acid Reflux	Gout Dermatitis Diabetes:Type 1, 2											
☐ Sleep Apnea ☐ Acid Reflux ☐ Kidney Disease	☐ Dermatitis ☐ Diabetes:Type 1, 2 ☐ Thyroid:Hyper/Hypo	Corneal Disease/Keratoconus Retinal Disorder/Detachment										
☐ Sleep Apnea ☐ Acid Reflux ☐ Kidney Disease ☐ Prostate Disease	☐ Dermatitis ☐ Diabetes:Type 1, 2 ☐ Thyroid:Hyper/Hypo ☐ High Cholesterol	Corneal Disease/Keratoconus Retinal Disorder/Detachment Strabismus (Lazy eye)		000	000			000				
☐ Sleep Apnea ☐ Acid Reflux ☐ Kidney Disease ☐ Prostate Disease ☐ Pregnancy	☐ Dermatitis ☐ Diabetes: Type 1, 2 ☐ Thyroid: Hyper/Hypo ☐ High Cholesterol ☐ Lupus	Corneal Disease/Keratoconus Retinal Disorder/Detachment Strabismus (Lazy eye) List all medications (in	clu	de e	ye d	rop		000				
Sleep Apnea Acid Reflux Kidney Disease Prostate Disease Pregnancy Osteoarthritis	☐ Dermatitis ☐ Diabetes: Type 1, 2 ☐ Thyroid: Hyper/Hypo ☐ High Cholesterol ☐ Lupus ☐ Sjogren's	Corneal Disease/Keratoconus Retinal Disorder/Detachment Strabismus (Lazy eye)	clu	de e	ye d	rop		000				
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	Pulse:	Pulse:  Weight:  Date:  you are here today?  Tired Eyes Dry eyes Sandy sensation Tearing/watery eyes Redness Burning Burning Itching  Ter day do you use computers/smart levices? # of hours/day  In you are here today?  Mucous discharge Crusty discharge Crusty discharge Stye/Eyelid Infection Eye Pain Floaters/flashes	# packs/day Former smoker? Quit da # packs/day Use recreational drugs? Types:	# packs/day # of Former smoker? Quit date: # packs/day Use recreational drugs? Types: # ti # packs/day Use recreational drugs?	# packs/day # of year Former smoker? Quit date: # packs/day Use recreational drugs? Types: # times.  # was your last eye exam?    Past Family History Has anyone in your family eve conditions?    Past Family History Has anyone in your family eve conditions?    You are here today?	# packs/day # of years Former smoker? Quit date: # packs/day Use recreational drugs? Types: # times/wee was your last eye exam?  Past Family History Has anyone in your family ever had conditions?  # packs/day Use recreational drugs? Types: # times/wee was your last eye exam?  Past Family History Has anyone in your family ever had conditions?  # packs/day # of years Former smoker? Quit date: # packs/day Use recreational drugs?  # packs/day Use recreati	# packs/day # of years Former smoker? Quit date: # packs/day Use recreational drugs? Types: # times/week    was your last eye exam? # times/week    Past Family History   Has anyone in your family ever had an conditions?    You are here today?	# packs/day # of years Former smoker? Quit date: # packs/day Use recreational drugs? Types: # times/week # ti	Smoke cigarettes/cigars/pipe/E-cigarettes now? # packs/day # of years Former smoker? Quit date: # packs/day Use recreational drugs? Types: # times/week  Past Family History Has anyone in your family ever had any of the conditions?  # you are here today?   Tired Eyes   Mucous discharge   Dry eyes   Crusty discharge   Headaches   Eye Pain   Burning   Floaters/flashes   Eye Pain   Burning   Floaters/flashes   Itching   Medical   Cancer   Dry eyes   Dry eyes	Smoke cigarettes/cigars/pipe/E-cigarettes now?   Yes # packs/day # of years   Former smoker? Quit date:   Yes # packs/day   # of years   Former smoker? Quit date:   Yes # packs/day   Use recreational drugs?   Yes   Types:   # times/week   Yes   Types:   Types:   # times/week   Yes   Types:   Types:	Smoke cigarettes/cigars/pipe/E-cigarettes now?   Yes	

## PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent.

The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care options. You have the right to revoke this Consent, Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have have already made based on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## The Patient Understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- · The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by	Printed Name: Patient or Representative	Signature	Date
	Relationship to Patient (if another than patie	ent)	15
Witness:			