



# New Patient Registration

(Please fill out all 4 pages.)

Federal regulations require that we confirm the identity of patients using insurance with a photo ID.

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_  
Street Apt  
\_\_\_\_\_ City State ZIP

Gender  Female  Male Date of Birth \_\_\_\_\_

SSN \_\_\_\_\_ How would you prefer to be contacted?  
 phone  email  text

Email \_\_\_\_\_

Best phone number to reach you \_\_\_\_\_

Alternate number \_\_\_\_\_

Your Employer (or school) \_\_\_\_\_

Vision Plan \_\_\_\_\_ Medical Insurance \_\_\_\_\_  
Company ID Company ID

To help speed the processing of your claims please let us make a copy of your insurance cards. If you are not the primary insured, please complete the information below:

Name of insured: \_\_\_\_\_ Date of birth \_\_\_\_\_

Address:  Same as above, or  
\_\_\_\_\_  
\_\_\_\_\_

Employer: \_\_\_\_\_ SSN \_\_\_\_\_

The primary insured is the patient's  spouse  parent

**Medical History**

Please answer the questions as completely as you can. The doctor will review your answers with you and discuss any eye health concerns you may have that are not covered here.

**Are you in general good health? If not, what are your major concerns?**

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**Do you smoke or use tobacco?**  Yes  No

**Do you drink alcohol?**  Never  Occasionally  1-3 times per week  Daily

**Are you currently taking and prescription medications?**

**If you are, please list them:** \_\_\_\_\_

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**Do you have problems in any of these areas?**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Gastrointestinal (Stomach, intestines, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Genitourinary                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood or lymph                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Serious Headaches                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nervous system                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Endocrine disorders (diabetes, thyroid)      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Respiratory                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Mental health                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cardiovascular (heart)                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ear/nose/throat                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Musculoskeletal                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergies/immune system                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**Is there a history in your family of any of the following?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Glaucoma           | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Retinal detachment | <input type="checkbox"/> Cataracts           |

**Have you had any type of eye surgery?**

**Do you have problems with**  **dry eyes**  **blurred vision?**

**Do you wear glasses or contact lenses?**

**Are you having any vision problems at this time?**

**Doctor's notes:**

**By** \_\_\_\_\_

**Assignment, Release, and Acknowledgement**

I authorize payments of benefits directly to The Eye Site for services rendered. I also authorize release of any medical information that may be required in determination of such benefits. I understand some services may require approval of my primary care physician for coverage and that if I do not obtain that approval I am financially liable for the services. I understand that my insurance carrier(s) may not cover some services and products and benefit information does not constitute approval for payment.

Deductibles and fees not paid by my insurance carrier will be my responsibility.

I acknowledge that I have received a copy of The Eye Site's NOTICE OF PRIVACY ACT (also known as the HIPAA Policy).

**Signature of patient** \_\_\_\_\_

**Or guardian** \_\_\_\_\_

**Please tell us how you found us:**

- We are listed as a provider by your insurance company**
- You were referred to us by family or friends**
- Advertising in \_\_\_\_\_**
- On an Internet search**
- Yellow Pages**
- Other \_\_\_\_\_**

**For your security:**

The Eye Site will not use any information collected from you for any purpose other than to satisfy your eye care needs and file claims with your insurance carrier. We will not give or sell your information (name, address, DOB, SSN, etc.) to any third party.

In addition, The Eye Site does not retain any credit or debit card information belonging to our patients. If you pay by card, be assured that we will not make or keep any card information in our files.