Eye Physicians & Surgeons, LLP

Patient Registration Form

Patient Information

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

Birthday: _____**Home Phone:** (____) _____ **Cell:** _____

Address:_____**City:** _____**State:**_____ **Zip:** _____

Email Address: _____

Would you like access to the online Patient Portal? Y N

Sex: Male __ Female __ **Marital Status:** Single__ Married__ Divorced __ Widow __ **SS#**_____/____/_____

Race: **White** **Asian** **Black/African American** **Native American** **Other**

Ethnic Group: **Hispanic/Latino** **Non Hispanic/Latino** **Unknown** **Preferred Language:** _____

Patient Insurance:

Name of Insurance: _____ **Are you the policy holder?** Y N

If No: Name of policy holder:_____ Relationship_____ DOB _____

Do you have a Secondary Insurance: Y N

Name of policy holder:_____ Relationship_____ DOB _____

Is this a Workers Compensation visit? Y N

If Yes: Your social security # _____ Date of Injury: _____

Employer Name:_____Address:_____

Phone:_____ Fax_____ Supervisor Name_____

Has treatment for today's injury been authorized? Y N If Yes, by whom? _____

Pharmacy Information:

Pharmacy Name: _____ **Address:** _____

Authorization to Discuss Health Information with Others:

With whom may we discuss your care? Name_____Relationship_____

Emergency Contact - Name_____Relationship_____ Phone_____

- I understand that I am financially responsible for all charges not covered by insurance.
- I authorize Eye Physicians & Surgeons to communicate with me by phone, answering machine, letter regarding appointments, medical care or billing.
- I agree to the release of my medical information to my primary care physicians or optometrists for continuation of care.

By signing you agree that to the best of your knowledge the information provided is true and accurate

Patient Signature _____ **Date** _____

Eye Physicians & Surgeons, LLP

Exceptional care. Focused on you.

ACKNOWLEDGEMENT OF EYE PHYSICIANS & SURGEONS NOTICE OF PRIVACY PRACTICES

I hereby acknowledge by signing below that a copy of Eye Physicians & Surgeons Notice of Privacy Practices brochure is available to read in office and online at www.iowaeyephysicians.com. I understand that I can also request a personal copy of the Privacy Practices brochure.

HIPAA

_____ _____

Patient Signature Date

_____ _____

*Person Signing on behalf of patient Date

_____

*Relationship to Patient