The Eye Center

**REGISTRATION FORM**

(Please print)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Today’s date: | | PCP/Family Doctor: | | | | | |
| **PATIENT INFORMATION** | | | | | | | |
| Patient’s last name: First: Middle: | | | | | | | |
| Birth date: | Sex:  M F | | Social Security no.: | | | | Home phone no.: |
| Street Address: | | | | | | | Cell phone no.: |
| P.O. box: | City | | | State | | Zip code: | Work phone no.: |
| Occupation: | | | | | Employer: | | |
| **Referred to clinic by:**  Yellow Pages-Book  Yellow Pages-Online  Friend or Family Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Doctor’s Name)* | | | | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **INSURANCE INFORMATION** | | | | |
| (Please give your insurance card(s) to the receptionist.) | | | | |
| Person responsible for bill: | Birth date: | Address (if different): | | Home phone no.: |
| Subscriber’s name: | Subscriber’s S.S. no.: | Birth date: | Group no.: | Policy no.: |
| Patient’s relationship to subscriber: Self Spouse Child Other | | | | |

|  |  |  |
| --- | --- | --- |
| **IN CASE OF EMERGENCY** | | |
| Name of friend or relative (not living at the same address)  and relationship to patient: | Home phone no.: | Work phone no.: |

|  |
| --- |
| The information provided on my REGISTRATION FORM and MEDICAL HISTORY is true to the best of my knowledge. I authorize my insurance benefits to be directly paid to Richard E. Ehlers, M.D. at 3403 Powerhouse Road, Yakima, WA 98902 for services rendered. I understand that I am financially responsible for any deductibles or any non-covered services. I also understand that this authorizes Richard E. Ehlers, M.D. to release any information requested by the insurance company in regards to my benefits.  By my signature below I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES. This document describes in detail how your health information may be used and disclosed, and how you can access your information.  **This agreement is in effect until revoked in writing by the patient.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Patient/Guardian signature Date* |

Reason for today’s visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any past eye injuries or surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any family history of eye problems such as Glaucoma or Macular Degeneration:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last eye exam and performing doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Imaging Purposes: Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_

Are you being treated for or having problems

with any of the following:

|  |  |  |
| --- | --- | --- |
|  | Yes | No  Allergies: |
| Diabetes ( Type 1 , Type 2 ) |  |  |
| Headache |  |  |
| Heart Disease |  |  |
| Hepatitis |  |  |
| High Blood Pressure |  |  |
| HIV positive or have AIDS |  |  |
| Lung Disease |  |  |
| MRSA |  |  |
| Rheumatoid Arthritis |  |  |
| Skin Diseases |  |  |
| Stomach Problems |  |  |
| Stroke |  |  |
| Thyroid Disease |  |  |
| Do you smoke? |  |  |

Current Medications (Prescription AND over the counter)

If available, please give list to receptionist

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Dose | Frequency | Route |
|  |  |  |  |

Allergies: