The Eye Center

**REGISTRATION FORM**

(Please print)

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| --- | --- |
| 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-BookYellow Pages-Online Friend or Family Doctor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Doctor’s Name)*  |

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| **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 |

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| **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.: |

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| 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:

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| --- | --- | --- |
|  | Yes | NoAllergies: |
| 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: