PATIENT REGISTRATION

In order to provide you the best possible care, please complete these forms. All information is strictly CONFIDENTIAL.

GENERAL INFORMATION (PLEASE PRINT)

Full Legal Name: _____ Preferred Name: _____

Street Address: _____ City, State, Zip: _____

Daytime Phone: _____ Mobile Phone: _____ Text: Y / N

Email: _____

Preferred Method of Contact: _____ cell phone / email / text / other (please explain)

Patient Social Security #: _____ Date of Birth: _____ Male / Female

Occupation: _____ Marital Status: married / single / divorced / legally separated / widowed

Language, Race, Ethnicity: _____

Emergency Contact Person & Phone #: _____

GUARDIAN INFORMATION (if patient is under 18 years of age)

Full Legal Name: _____

Daytime Phone: _____ Mobile Phone: _____ Text: Y / N

Email: _____

Street Address: _____ City, State, Zip: _____

FINANCIAL ASSIGNMENT INFORMATION

I understand and agree to provide all insurance information at the time of service. By failing to do so, I expect full responsibility for all unpaid totals. Insurance information will not be accepted after the date of service for services and materials provided on date of service. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me. I understand and agree that all services rendered to me and charged are my personal responsibility for timely payment. I understand that if I suspend or terminate my care/ treatment, any fees for professional service rendered to me will be immediately due and payable.

Signature agreeing to all above terms: _____ Date: _____

GENERAL MEDICAL HISTORY

NAME OF PRIMARY CARE DR. : _____ PHONE #: _____

HEIGHT:_____ WEIGHT:_____ DO YOU SMOKE? Y / N HAVE YOU EVER SMOKED? Y / N

PREGNANT OR NURSING? Y / N

PATIENT MEDICAL HISTORY *PATIENT OCULAR HISTORY*

****PLEASE CIRCLE ALL THAT APPLY TO THE PATIENT ONLY IN THIS SECTION****

CANCER	Y / N	MULTIOLE SCLEROSIS(MS)	Y / N	CATARACTS	Y / N
SEIZURES	Y / N	MIGRANES	Y / N	GLAUCOMA	Y / N
DEPRESSION/ANXIETY	Y / N	BIPOLAR	Y / N	MACULAR DEGEN.	Y / N
ADD/ADHD	Y / N	HIGH BLOOD PRESSURE	Y / N	DRY EYE	Y / N
STROKE	Y / N	HEART DISEASE	Y / N	BLINDNESS	Y / N
ASTHMA	Y / N	SLEEP APNEA	Y / N	LAZY EYE	Y / N
GI CONDITIONS	Y / N	ACID REFLEX	Y / N	RETINAL CONDITION	Y / N
KIDNEY DISEASE	Y / N	ARTHRITIS	Y / N		
SKIN CONDITIONS	Y / N	SHINGLES	Y / N		
COLD SORES	Y / N	THYROID DISFUNCTION	Y / N		
DIABETES	Y / N	HIGH CHOLESTEROL	Y / N		
ULCERS	Y / N	ALLERGIES	Y/ N		
LUPUS	Y / N	AIDS/HIV	Y / N	*LATEX SENSITIVITY*	Y / N

FAMILY MEDICAL HISTORY *FAMILY OCULAR HISTORY*

****PLEASE CIRCLE ALL THAT APPLY TO THESE FAMILY MEMBERS ONLY IN THIS SECTION.... M=MOTHER, F= FATHER, B= BROTHER, S= SISTER****

CANCER	FAMILY (M F B S)	CATARACTS	FAMILY (M F B S)
DIABETES	FAMILY (M F B S)	GLAUCOMA	FAMILY (M F B S)
HIGH BLOOD PRESSURE	FAMILY (M F B S)	MACULAR DEGEN.	FAMILY (M F B S)
THYROID DISFUNCTION	FAMILY (M F B S)		

CURRENTLY WEAR GLASSES? Y / N CURRENTLY WEAR CONTACTS? Y / N INTEREST IN CONTACTS? Y / N

ARE YOU INTERESTED IN LEARNING MORE ABOUT LASIK? Y / N

PLEASE LIST DRUG AND/ OR ENVIROMENTAL ALLERGIES BELOW:

PLEASE LIST ALL MEDICATIONS (including all over-the-counter, vitamins, herbal, and prescription medications)

NAME	DOSAGE	USED FOR

ACKNOWLEDGEMENT
OF
NOTICE OF PRIVACY PRACTICES

The law requires that Biermann Eye Health P.C. make every effort to inform you of your rights related to your personal health information. By my signing below, I acknowledge that:

- ☐ I have read or had explained to me Biermann Eye Health P.C.'s Notice of Privacy Practice and agree to continue my care with Biermann Eye Health P.C. under said terms.
- ☐ I was given to opportunity to read Biermann Eye Health P.C.'s Notice of Privacy Practices and declined but wish to continue my care with Biermann Eye Health P.C. under the terms of Biermann Eye Health P.C.'s privacy policies.
- ☐ I have read or had explained to me Biermann Eye Health P.C.'s Notice of Privacy Practice and do not wish to continue my care with Biermann Eye Health P.C. under said terms.
- ☐ The Notice of Privacy Practice could not be read due to the emergent nature of the care of other reason described as

_____

_____

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY.

_____ _____

Print Patients Full Name DOB

_____ _____

Patients Signature Date

If you are signing as a personal representative of the patient, please indicate your relationship

_____ _____

Representative Relationship to Patient

Our contact person for all questions, requests, or for further information related to the privacy of your health information is:

_____ _____

Contact Person/Persons Contact #