MOUNTAIN EYE INSTITUTE
New Patient Registration Form

Mr. Mrs. Ms. _________________Home Phone ____________Cell Phone___________

Address______________________City____________State____________Zip_________

Email Address:___________________________

SEX: M/ F STATUS: Single Married Divorced Widowed Minor

RACE: Caucasian Asian African-American Hispanic Indian Pacific Islander

ETHNICITY: American Asian French German Spanish Indian Native-American

Social Security Number: _______-________-________ Date of Birth:_____/____/_____

Who can we thank for referring you? __________________________________

Family Physician_______________________________Phone_________________

Relative or Friend NOT living with you_____________________ Phone_______________

INSURANCE: Please list Primary insurance carrier first.
OUR OFFICE WILL NEED TO PHOTOCOPY/SCAN YOUR INSURANCE CARD

PRIMARY______________________ID # _______________Group #______________

Subscriber: ____________________Date of Birth:____/_____/____

SECONDARY___________________ ID # _______________Group # _____________

Subscriber: ____________________Date of Birth:____/_____/_____

Responsible Party (Indicate Relationship)__________________________________

"By signing below I agree to pay all amount(s) owed within 90 days of when such amount(s) are incurred. **I understand that it is *MY* responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay *ALL* amounts owing as set forth herein.** I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% monthly) until paid in full. In the event any amount(s) is/are referred to a third party debt collections agency, I will be responsible for fees up to 40% as allowed by Utah Code Annotated, sec12-1-11.
YOUR CO-PAY(S) IS DUE AT THE TIME OF YOUR VISIT! On statements sent for co-pays (not paid at the time of your visit) a $5.00 processing charge will be added to your account.

I authorize the release of medical information concerning my illness/treatment by Mountain Eye Institute to my insurance company and/or other entities. I authorize payment of medical benefits to Mountain Eye Institute

Signature___________________________________Date_____________________

Mountain Eye Institute
1811 W Royal Hunte Dr. Ste. 1
Cedar City UT 84720
435-586-1131

Name____ **Date**___________________________

DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS:

	YES	NO	EXPLANATION OF PROBLEM	FOR CLINIC USE ONLY
Fever				
Weight Loss				
Other				
EARS, NOSE, THROAT (sinus, ear infection, chronic cough etc.)				
CARDIOVASCULAR (Heart, vessels, etc.)				
RESPIRATORY (Asthma, emphysema, etc.)				
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc.)				
GENITAL, KIDNEY, BLADDER				
MUSCLES,BONES, JOINTS (Arthritus, etc.)				
SKIN (Acne, warts,skin cancer, etc.)				
NEUROLOGICAL (MS, etc.)				
PSYCHIATRIC (Anxiety, depression, insomnia, etc.)				
ENDOCRINE (Diabetes, hypothyroid, etc.)				
BLOOD/LYMPH (Cholesterolemia, anemia, etc.)				
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, sjogrens, food, etc.)				

PLEASE LIST ALL CURRENTMEDICATIONS	**DOSAGES**	

PLEASE LIST ANY KNOWN DRUG/FOOD ALLERGIES:

____

____

LIST ANY PAST SURGERIES OR PROCEDURES IN PAST 5 YEARS:

FAMILY HISTORY MOTHER, FATHER, BROTHER, SISTER, GRANDMOTHER OR GRANDFATHER

DISEASE	YES	NO	NAME & RELATIONSHIP TO PATIENT
Macular Degeneration			
Glaucoma			
Cataract			
Arthritis			
Cancer			
Diabetes			
Heart disease or High BP			
Kidney Disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

CURRENT OCCUPATION: ____

Do you drink alcohol? YES NO	Number	TYPE	Frequency	#years	discontinued date: _______________
Current Drinker	Socially	Beer	day	2	
Never drinker	1	glasses	week	3	
	2	shots	month	4	
	3	Bottles	year	5	
	4+	Quarts		10+	

Do you smoke? YES NO	Number	TYPE	Frequency	#years	discontinued date: _______________
Every day smoker	socially	cigarette	day	1	
Former smoker	2	cigars	week	2	
Never	5+	pipe	month	3	
Heavy smoker		Pack	year	5+	
Light smoker					

Patient's Signature ____ **Date** _________________________

Physician's Signature ____ **Date** _________________________

Patient Contact List

I, ____, hereby authorize Mountain Eye Institute to release my medical information to the following people by phone or by message:

Name________________________________ Relationship to Patient__________________

Phone #_______________________________________

Name________________________________ Relationship to Patient__________________

Phone #_______________________________________

Name________________________________ Relationship to Patient__________________

Phone #_______________________________________

Name________________________________ Relationship to Patient__________________

Phone #_______________________________________

Name________________________________ Relationship to Patient__________________

Phone #_______________________________________

____ __________________

***Signature** of Patient (or Patient Representative) **Date**

____

Relationship to Patient

____ __________________

***Witness** **Date**

PRIVACY PRACTICE ACKNOWLEDGEMENT

By signing this form, you acknowledge that you have been informed that Mountain Eye Institute provides information about how we may use and disclose your Protected Health Information (PHI).

Mountain Eye Institute may use the following methods of communication regarding Information related to my personal health, treatment or payment for treatment. I Acknowledge I am responsible for updating this information as necessary. This request supercedes any prior request for methods of communication I may have made.

____ ____________________

Name of Patient **Patient Number**

___ **Home** ________________________________
___ **OK to leave a message with detailed information**
___ **Leave call back number only**

___ **Cell** ___________________________________
___ **OK to leave a message with detailed information**
___ **Leave call back number only**

___ **Work** __________________________________
___ **OK to leave a message with detailed information**
___ **Leave call back number only**

Questions or concerns about our Privacy Notice or Practices should be directed to the Privacy Officer at (435) 586-1131.

____ __________________

***Signature** of Patient (or Patient Representative) **Date**

____

Relationship to Patient

____ _______________

***Witness** **Date**