

# New Patient Registration Form

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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)

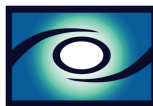
By signing below, I agree to pay all amount(s) owed within 90 days of when such amount(s) are incurred. I understand that it is MY responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, 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  
LASER & SURGERY CENTER

(435) 586-1131

[www.mountaineyeinstitute.com](http://www.mountaineyeinstitute.com)

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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 (Asthmas, emphysema, etc.)				
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)				
GENITAL, KIDNEY, BLADDER				
MUSCLES, BONES, JOINTS (Arthritis, 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 CURRENT MEDICATIONS	DOSAGES			

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PLEASE LIST ANY KNOWN DRUG/FOOD ALLERGIES:

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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	Frequency	# of Years
1	Day	1
2	Week	2
3	Month	5-10
4+	Year	10+

Do you smoke?    YES    NO

Number	Frequency	# of Years
1	Day	1
2	Week	2
3	Month	5-10
4+	Year	10+

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_



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# Patient Contact List

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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 Acknowledgment

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By signing this form, you acknowledge that you have been informed that Mountain Eye Institute supplies 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 supersedes 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



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