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 ________________________

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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:

____

____

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 _______________

(435) 586-1131

www.mountaineyeinstitute.com

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 Acknowledgment

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