New Patient Registration Form

Mr. Mrs. Ms. _____ Home Phone _____ Cell Phone _____

Mailing Address _____ City _____ State _____ Zip Code _____

Email Address: _____ Preferred Pharmacy _____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

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

Who can we thank for referring you? _____

Family Physician _____ Phone _____

Emergency Contact _____ Relationship _____ Phone _____

*****For Patients Under 18*****

Responsible Party _____ Date of Birth: _____/_____/_____

Relationship _____ Social Security Number: _____-_____-_____

OUR OFFICE WILL NEED TO PHOTOCOPY/SCAN YOUR INSURANCE CARD

INSURANCE: Please list Primary insurance carrier first.

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 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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DO YOU CURRENTLY HAVE ANY PROBLEMS IN THE FOLLOWING AREAS:

	Yes	No	Explanation of Problem
OCULAR (Cataracts, Glaucoma, ARMD, Surgery, etc...)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, sjogrens, etc.)			
CARDIOVASCULAR (Heart, vessels, etc.)			
ENDOCRINE (Diabetes, hypothyroid, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc..)			
GENITAL, KIDNEY, BLADDER			
BLOOD/LYMPH (Cholesterolemia, etc.)			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, etc.)			
SKIN (Acne, warts, skin cancer, etc.)			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
NEUROLOGICAL (MS, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia, etc.)			
RESPIRATORY (Asthmas, emphysema, etc.)			

PLEASE LIST ALL OCULAR MEDICATIONS	DOSAGES AND APPLICATION

PLEASE LIST ALL CURRENT MEDICATIONS	DOSAGES

Mountain Eye Institute
LASER & SURGERY CENTER

CEDAR SURGICAL
PROVIDING HIGH QUALITY SURGERY AND CARE

New Patient Registration Form

PLEASE LIST ANY KNOWN DRUG/FOOD ALLERGIES:

_____

_____

LIST ANY PAST SURGERIES OR PROCEDURES IN THE PAST 5 YEARS

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

DISEASE	YES	NO	
Macular Degeneration			
Cataract			
Glaucoma			
Retinal Detachment			
Arthritis			
Cancer			
Diabetes			
Heart disease or High BP			
Kidney Disease			
Thyroid disease			
Stroke			
Other			

SOCIAL HISTORY:

CURRENT OCCUPATION _____

Smoking History:

X	Check the box that applies:
	Never Smoker
	Former Smoker
	Current Everyday Smoker
	Current Occasional Smoker

Alcohol History:

X	Check the box that applies:
	None
	Occasional / Social
	1-2 Drinks Daily
	3-4 Drinks Daily

Patient's Signature _____ Date _____

Mountain Eye Institute
LASER & SURGERY CENTER

CEDAR SURGICAL
PROVIDING HIGH QUALITY SURGERY AND CARE

New Patient Registration Form

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

Mountain Eye Institute and Cedar Surgical Associates 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 Account Number

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

Name _____ Relationship to Patient _____

Phone # _____

Name _____ Relationship to Patient _____

Phone # _____

Name _____ Relationship to Patient _____

Phone # _____

Messages

Please indicate your preferred method of communication:

Text **Call** **Email**

Phone # or Email Address: _____

When leaving a message I would prefer a: detailed message message requesting

The best time to reach me is: morning evenings anytime

_____ _____

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

_____

Relationship to Patient

_____ _____

***Witness** (Office Use Only) Date

Mountain Eye Institute LASER & SURGERY CENTER

CEDAR SURGICAL PROVIDING HIGH QUALITY SURGERY AND CARE