Patient Registration

Welcome to the office! Please help us maintain your records by filling out this brief form.

Name _____ Age_____ DOB _____ Last 4 digits of SSN_____

If patient is a minor, Parent/Guardian Name _____

Primary Insurance Holder _____ DOB _____ Last 4 digits of SSN_____

Patient Billing/Mailing Address _____

City _____ State _____ Zip _____

Mobile Phone _____ ☐ Check if text okay for notification and confirmation

Secondary Phone_____

Email_____

Employer _____ Occupation _____

How were you referred to our office?

☐ Insurance List ☐ Our Website ☐ Google ☐ Yelp ☐ Internet

☐ Another Patient _____ ☐ Nurse/Doctor _____

Sex (MU)*: ☐ Male ☐ Female ☐ Decline to specify/Other _____

Ethnicity (MU)*(circle one): White; Black or African American; Hispanic; Asian; American Indian/Alaska Native; Native Hawaiian or Other Pacific Islander; Decline to specify/Other _____

Preferred contact method (MU)*: ☐ Call ☐ Text ☐ Email

We accept all major credit cards and personal checks with a valid driver's license. One-half of your total bill is necessary to start your order for glasses or contact lenses. The balance is due at pick-up.

I understand that regardless of my insurance status, I am responsible for the balance on my account for any services rendered. I certify the above information is correct. _____ [initials]

Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

I, _____, have received a summary copy of the Notices of Privacy Practices for Desert Eye, PC. I understand that I can request a complete detailed copy of this document at any time.

Signature_____ Date _____/ _____ /_____

If not self, description/title of personal representative's authority _____

*(MU)—meaningful use) for internal use only