Kvitle Eye Care Associates New Patient Registration Form

PATIENT INFORMATION

Name (Last, First, Middle): _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____

Cell Phone (_____)_____ ☐ Ok to text

Home Phone(_____)_____

Communication Method: ☐ Text ☐Call ☐ Email

Email Address: _____

Employer: _____ Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Spouse (Last, First, Middle): _____

Emergency Contact: _____

Relationship: _____

Emergency Contact Phone: (_____)_____

If the Patient is a minor (under the age of 18), please provide information for the parent or legal guardian.

Parent/Legal Guardian Name: _____ Phone: (_____)_____

Meaningful Use

Race: ☐ Declined to Specify ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

Ethnicity: ☐ Declined to Specify ☐Hispanic or Latino ☐ Not Hispanic or Latino

Preferred Language: ☐ Declined to Specify ☐ Unspecified ☐ English ☐ Spanish Other_____

Referred by: _____

MEDICAL HISTORY

Reason for Visit: _____

Please List Any Current or Past Medical Problems and Approximate Dates: _____

_____

_____

Please List All Current Medications, Dosage, and Duration: _____

_____

_____

Please List Any Allergies to Medications: _____

_____

MEDICAL HISTORY CONTINUED

Please List Any Major Surgeries and Approximate Dates: _____

_____

Please List Any Family History of Major Current or Past Medical Problems: _____

_____

_____

_____

Do you drink alcohol? ☐ Yes ☐ No If so, how often: _____

Do you smoke cigarettes? ☐ Yes ☐ No If so, how often: _____

Do you take illegal drugs? ☐ Yes ☐ No

AUTHORIZATION

I certify that the above information is true and accurate. I authorize the release of any medical or other information necessary to process a claim or continue medical treatment. I also authorize payment of medical benefits paid directly to **Kvitle Eye Care Associates**. I acknowledge that I am responsible for payment if my insurance company denies my claim.

_____ _____

Patient Signature Date

_____ _____

Parent or Legal Guardian Signature (If patient is a minor) Date