Nethery Eye Associates

PATIENT REGISTRATION FORM Date _____

Name _____ Male _____ Female _____
First Middle Last

Email Address _____

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security _____ Date of Birth _____

Ethnicity: ____Hispanic or Latino ____Not Hispanic or Latino ____Unknown ____Decline to Specify

Race: ____American Indian or Alaska Native ____Asian ____Black or African American

____Native Hawaiian or Other Pacific Islander ____White ____Other ____Decline to Specify

Employer _____ Occupation _____

Employer Address _____ City _____ State _____ Zip Code _____

Spouse _____ Work Phone _____ Cell Phone _____

Parent/Guardian _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Nearest Relative _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell Phone _____

Referred by _____

Continued on Reverse Side

Patient Name _____

(Please Print)

I hereby authorize my doctor to release to the Social Security Administration or other insurance carriers any medical or other information needed for all services that I receive. I request that all insurance payments be made directly to my doctor. I understand if my insurance does not pay within 45 days or decides the service is "non-covered" that a bill will be sent directly to me. I further understand that I am responsible for any deductibles, co-insurance, and refraction fees at the time of service.

Signature _____ Date _____

I also understand that, if at any time, I change my insurance coverage to a managed care plan (i.e. Secure Horizons, Pacificare, or any other comparable plan) or change my primary physician, I am responsible for notifying your office of such change. If I fail to obtain a valid referral prior to my visit and I decide to be seen by Nethery Eye Associates, I understand that my services will be considered out of network and I will be solely responsible for the fees incurred.

Signature _____ Date _____

WE NEED ALL INFORMATION COMPLETED AND SIGNED
IN ORDER TO FILE WITH YOUR INSURANCE

Without correct information, you will be financially responsible for services rendered that day.

Nethery Eye Associates

PLEASE PRINT Today's Date _____

Patient Name _____ Date of Birth _____

Primary Care Physician and Phone Number _____

Optometrist Name _____ Pharmacy Name _____

Pharmacy Address and Phone Number _____

Past Medical History - Please check the box and list the date of onset

- ☐ Anxiety _____
- ☐ Arthritis _____
- ☐ Asthma _____
- ☐ Atrial Fib (Irregular Heart Beat) _____
- ☐ Bone Marrow Transplant _____
- ☐ BPH/Urinary Problems _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ COPD/Emphysema _____
- ☐ Coronary Artery Disease _____
- ☐ Depression _____
- ☐ Diabetes Type I _____
- ☐ Diabetes Type II _____
- ☐ End Stage Renal Disease _____
- ☐ GERD _____
- ☐ Hearing Loss _____
- ☐ Hepatitis _____
- ☐ Hypertension _____
- ☐ HIV/AIDS _____
- ☐ Hypercholesterolemia _____
- ☐ Infectious Disease _____
- ☐ Leukemia _____
- ☐ Liver Disease _____
- ☐ Lung Disease _____
- ☐ Lymphoma _____
- ☐ Prostate Cancer _____
- ☐ Radiation Therapy _____
- ☐ Seizures _____
- ☐ Stroke _____
- ☐ Thyroid Disease (Hyper/Hypo) _____

Please list any surgeries you have had: _____

_____

Please list any allergies: _____

Ocular History

Have you been diagnosed with any eye condition/disease? If yes, please check the box and list the date of diagnosis.

- ☐ Cataracts _____
- ☐ Dry Eyes _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Retinal Detachment _____

Please continue on reverse side

Have you had any eye surgeries? If yes, please list type of surgery, date of surgery, and name of surgeon.

_____

_____

_____

Do you use eye drops? ☐ Yes ☐ No

If yes, please list the name of eye drops you are currently using: _____

_____

_____

_____

Are you currently taking any medications? ☐ Yes ☐ No

If yes, please list medications: _____

_____

_____

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list medications: _____

_____

Have you ever smoked? ☐ Yes ☐ No When did you quit? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks do you have in a typical day? _____

If over age 65, how many times in the past year have you had 4 or more drinks in a typical day? _____

Current Occupation _____

If retired, please list previous occupation: _____

What are your hobbies/interests? _____

Do you have a family history of: (if yes, please list relation)

Diabetes	Yes ☐	No ☐	Who: _____
Stroke	Yes ☐	No ☐	Who: _____
Heart Attack	Yes ☐	No ☐	Who: _____
Glaucoma	Yes ☐	No ☐	Who: _____
Macular Degeneration	Yes ☐	No ☐	Who: _____

Notice of Privacy Practices - Review Acknowledgement

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative (Please Print)

_____

If not patient, please describe Personal Representative's authority

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Please list the names of the persons you authorize Nethery Eye Associates to communicate with regarding your medical care:

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship

_____

Name Relationship