PATIENT REGISTRATION FORM

PLEASE COMPLETE THE ENTIRE FORM – BOTH SIDES

PATIENT INFORMATION

Last Name:____ First Name:__________________________ M.I._____

Social Security #:___________________________________ Date of Birth: _______________ Gender: M F (circle one)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

Race: ☐ Decline to specify ☐ Asian ☐ African American ☐ American Indian or Alaska Native ☐ Caucasian
☐ Native Hawaiian or Other Pacific Islander ☐ Other:_______________________________________

Ethnicity: ☐ Decline to specify ☐ Hispanic/Latino ☐ Not Hispanic/Not Latino ☐ Other:_________________

Mailing Address:____

City:____ State:____________________ Zip:_________________

Email Address:____

Home Phone:________________________ Cell Phone:______________________ Work:__________________________

Driver's License Number:________________________________ Spouse's Name:_________________________________

Referring Physician:__________________________________ Primary Care Physician:_____________________________

City:__________________________________ City:_______________________________

PERSON RESPONSIBLE FOR THE BILL - Only applicable if other than patient:

Last Name:____ First Name:__________________________ M.I._____

Relationship to patient:________________________________ Home Phone:____________________________________

Mailing Address:____

City:____ State:____________________ Zip:_________________

INSURANCE INFORMATION

Primary Insurance Company: ☐ Medicare ☐ Medicaid ☐ Other:____

Policy #__________________________________ Group #_______________________ Effective Date:________________

Policy Holder Name: ____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other:____

Policy Holder's Date of Birth: _________________ Gender: M F Social Security #_____________________________

Employer:____ Phone:_____________________________________

Secondary Insurance Company: ☐ Medicaid ☐ Other:____

Policy #__________________________________ Group #_______________________ Effective Date:________________

Policy Holder Name: ____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Other:____

Policy Holder's Date of Birth: _________________ Gender: M F Social Security #_____________________________

Employer:____ Phone:_____________________________________

CONTINUED ON OTHER SIDE:

ADDITIONAL PATIENT INFORMATION:

Employment: ☐ Active Duty ☐ Full Time ☐ Not Employed ☐ Part Time ☐ Retired ☐ Self Employed

☐ Student – full time ☐ Student – part time

Name of Employer:____ Occupation:____________________________________

Preferred Language: ☐ English ☐ Spanish ☐ Other:____

Emergency Contact:____ Relationship:__________________________________

Emergency Contact Home Phone:____________________________________ Cell Phone:________________________________

Local Pharmacy Name:____ City:___________________________________

Pharmacy Phone____

How did you hear about our doctor? ☐ TV ☐ Newspaper ☐ Web search ☐ Radio ☐ Doctor:________________

☐ Friend/Family – Name:____

IMPORTANT INFORMATION

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by Bryan Frazier, OD physicians, employees and such associates, assistance, and other health care providers as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations and treatment. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I receive care from this practice, unless revoked by me in writing.

RELEASE OF INFORMATION: I understand my signature authorizes release of confidential medical information necessary to pay the claim to Medicare or other health insurer. I understand that I may revoke this authorization at any time, by providing written notice to Bryan Frazier, OD, except to the extent that action has been taken in reliance on it.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title and interest in all insurance, Medicare/Medicaid, or other third party payor benefits for medical or health care services payable to me, payable to the providers of Bryan Frazier, OD I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third party payor, up to the total amount of my medical and health care charges, to the providers of Bryan Frazier, OD I certify that the information I have provided in connection with any application for payment by third party payors, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the estimated amount to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third party payor and agree to make payment as requested by Bryan Frazier, OD

REFRACTION: I understand that the refraction (measurement of eyes for glasses / contacts) is a NON-COVERED service. I accept full financial responsibility for the cost of this service. The co-pay is separate from and not included in the refraction fee.

NOTICE OF PRIVACY PRACTICES: I acknowledge that a copy will be made available upon my request.

____ ________________________________

Signature of patient (or responsible party) Date

MEDICAL INFORMATION

DATE ___________________________________ REFERRING PHYSICIAN ____

CITY ____

NAME ___________________________________ PRIMARY CARE PHYSICIAN______________________________________

CITY ____

PAST MEDICAL HISTORY

Medical History (Do you have any of the following conditions):

_____ Asthma
_____ Arthritis
_____ Cancer
- _____ Breast Cancer
- _____ Colon Cancer
- _____ Leukemia
- _____ Lung Cancer
- _____ Lymphoma
- _____ Prostate Cancer

_____ Diabetes
_____ Emphysema (COPD)
_____ Heart Disease
- _____ Atrial Fibrillation (*irregular heartbeat)*
- _____ Coronary Artery Disease

_____ Hepatitis
_____ High Cholesterol *(Hypercholesterolemia)*

_____ High Blood Pressure
_____ HIV
_____ Stroke
_____ Thyroid Disease
- _____ Hyperthyroidism
- _____ Hypothyroidism

_____ Other (Please list)
____
____

Past Surgical History:

OCULAR HISTORY

(List any eye conditions and/or eye surgeries)

Eye Conditions:

Eye Surgeries:

Family History of:

☐ Cataract _______________________________________
☐ Cross Eyes *(Strabismus)* ___________________________
☐ Diabetes _______________________________________
☐ Eye Disorders ___________________________________
☐ Glaucoma _______________________________________
☐ Heart Disease ___________________________________
☐ High Blood Pressure ______________________________
☐ Lazy Eyes (Amblyopia) ____________________________
☐ Retinal Detachment _______________________________
☐ Other ____

CURRENT MEDICATIONS:

MEDICATION ALLERGIES:

TURN OVER

SOCIAL HISTORY:

Drug Use ____

Alcohol Use: ☐ None ☐ Less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Smoking Status: ☐ Never smoked ☐ Former Smoker ☐ Current Some Days Smoker ☐ Current Every Day Smoker

Do you still drive in the daytime? ☐ Yes ☐ No Do you still drive at night? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No Do you feel safe at home: ☐ Yes ☐ No

Do you exercise? ☐ Yes ☐ No If yes, how much?____

REVIEW OF SYSTEMS:

Do you have any problems in the following areas? Please check all that apply.

1 – General Health	☐ Normal	☐ Fever
2 – Eyes	☐ Normal	☐ Blurred Vision
3 – Ears, Nose, Mouth, Throat	☐ Normal	☐ Hearing Loss
4 – Cardiovascular	☐ Normal	☐ Chest Pain
5 – Respiratory	☐ Normal	☐ Shortness of Breath
6 – Gastrointestinal	☐ Normal	☐ Stomach Pain
7 – Hematology	☐ Normal	☐ Free Bleeder
8 – Musculoskeletal	☐ Normal	☐ Weakness
9 – Integumentary (Skin/Breast)	☐ Normal	☐ Tumors
10 – Neurologic	☐ Normal	☐ Numbness
11 – Genitourinary		☐ Currently Pregnant

____

Reviewed by: Date:

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Reviewed by: Date:

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Reviewed by: Date:

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Reviewed by: Date:

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