PATIENT REGISTRATION SHEET (rev 12/18) **Today's Date**_____

How did you hear about us? ___Website ___Facebook ___Newspaper ___ Friend ___ Family Member ___Doctor Referral Other _____

Mr Mrs Miss Ms Dr Rev Sister:_____
(circle one) FIRST NAME MIDDLE INITIAL LAST NAME
Mailing Address: _____
_____ZIP PLUS 4: __ __ __ __ __ - __ __ __ __
e-mail address: (required, if available)_____
Sex: M F **Marital Status:** Single Married Divorced Widowed Legally Separated
Social Security Number: __ __ __ - __ __ - __ __ __ __ **Date of Birth:** __ __- __ __ - __ __ __ __
Race: (circle one) White American Indian or Alaskan Asian Black/African American Other _____
Ethnicity: (circle one) NOT Hispanic or Latino Hispanic or Latino Unknown
Primary Language: (circle one) English Spanish Other_____
Home Phone Number: ( )_____ **Work Phone:** ( )_____
Cell Phone Number: ( )_____ **Carrier:** (Circle one) Verizon AT&T Sprint Other_____
Reminder call preference: (circle one) call home phone / call cell phone/ email / text message

Your Employer:_____ Phone:_____
Address:_____
Your Occupation:_____ Retired: Y N
Spouse Name:_____**Spouse Employer**:_____

Medical Doctor:_____ City:_____
Emergency Contact Person(s): _____ Relationship:_____Phone:_____
Is there anyone you would like to give permission to inquire about your medical records at our office?
Name(s):_____
Relationship(s):_____

Insurance Information: (Please present your cards to the receptionist to be copied)
Medicare: _____ Medicaid: __ __ __ __ __ __ __ __ __

Medicare Supplement Insurance Name:_____
Policy Number: _____

Health Insurance Name: _____Policy Number: _____
Policyholder Name: _____ Policyholder Date of Birth: __ __/__ __/__ __ __ __

Vision Insurance Name: _____ ___Policy Number: _____
Policyholder Name: _____ Policyholder Date of Birth: __ __/__ __/__ __ __ __

Is your visit here the result of an accident? YES NO ( )work related ( ) automobile ( ) other
Insurance Company Name: _____Job Site Supervisor Name: _____
Date of Injury _____ Brief Description of Accident _____
_____
On occasion, we make appointment reminder calls.
May we leave a message on your answering machine? (Circle one) YES NO Don't have answering machine
May we call you at work? (circle one) YES NO I am retired

PLEASE READ AND SIGN THE PATIENT CONSENT FORM/ASSIGNMENT ON THE BACK OF THIS INFORMATION SHEET

The HIPAA Privacy Rule gives individuals a fundamental right to be informed of the privacy practices of health plans and health care providers, as well as to be informed of their privacy rights with respect to their personal health information. This notice describes how medical information about you may be disclosed and how you can get access to this information. Please review it carefully.

Your Information. Your Rights. Our Responsibilities.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

This represents a summary of your rights. The complete notice is available by requesting it from our receptionist.

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

It is the patient/guardian responsibility to know their insurance coverage. Patients should be aware of their benefits, including which providers are contracted with their plan, covered and non-covered benefits, authorization requirements, and cost share information such as deductibles, co-insurance, and co pays, and when they are eligible for services. If you are not familiar with your plan coverage, we recommend you contact your carrier directly prior to your services.

The patient/guardian authorizes payment of all private insurance, medical/surgical benefits, including major medical benefits to go to the Mabee Eye Clinic. A photocopy of this assignment is to be considered as valid as an original. The patient/guardian is financially responsible for all charges regardless of insurance.

Patient/Guardian Signature _____ Date _____
Guardian must sign if patient is under 18 years old

The Mabee Eye Clinic may share medical and/or billing information with the following persons involved with my care:

Name	Relationship	Date
Name	Relationship	Date
Name	Relationship	Date

Patient/Guardian Signature _____Date _____