NEW PATIENT REGISTRATION

Date: _______________

Patient Information:

First Name:_________________ MI ____ Last Name:_________________________________
Guardian (if applicable):____
Address:____
City: ____State:_______ Zip ___________________
E-Mail:____________________________________ Home Phone ________________________
Cell Phone: ________________________________ Work Phone: ________________________
Emergency Contact: Name ______________________________ Relationship ________________
Phone: _____________________________
Birth date: _____________________ Gender_______ Occupation _________________________
Employer: ____
Marital Status:____________________
Spouse's Employer ________________________________Spouse's Birth date________________
How did you hear about our practice? ____

Insurance:

Who is responsible for this account? ____
Relationship to patient: ____
Do you have Vision Benefits?_____Name of Vision Insurance______________________________
Vision ID Number:_______________________________
If VSP, last 4 digits of SSN for the person who carries the insurance: _______________

Name of Primary Medical Insurance: ____
I.D. number: ______________________________ Group #: _________________________
Name of Secondary Insurance (if applicable): ____
I.D. number: _______________________________ Group #: ________________________

Financial Assignment and Release of Information:

I certify that I, or my dependant(s), have insurance coverage as listed above and assign directly to Dr. Charles Griffen all insurance benefits, if any, otherwise payable to me for services rendered. I also understand that I am financially responsible for all charges whether or not paid by insurance, unless prior arrangements have been made. I authorize the use of my signature on all insurance submissions.
Signature of patient, parent or guardian:____

Acknowledgement of Notice of Privacy Practices (NPP):

I have read or had explained to me by this office the **NPP**, also know as **HIPAA,** or I was given the opportunity to read it and declined.
Signature of patient, parent or guardian:____

Patient General Health History:

Primary Care Physician: __________________________________Date of last visit:__________
List any conditions or diseases you are currently being treated for:
____
____
List any prior surgeries you have had and any prior serious illnesses or diseases you were treated for: ____
____

List all medications, vitamins and supplements you are currently taking: ____________________
____
____
____
List any allergies to medications: ____

Patient Eye Health History:

Prior Eye Doctor's Name: ___________________________________ Date of last visit: _________
Do you currently wear glasses? ________ If yes, for what reason(s) _________________________
____
Do you currently wear contact lenses? If yes, how often?_________________________________

List the brand and specifications of your contacts, if applicable:

Right eye: ____

Left eye: ____

Are you having any problems wearing your contacts? ______

If yes, please describe: ____
____

Did you previously wear contacts? ______ When and why did you stop? ___________________
____

Are you interested in being fit with contacts? _______

Did you ever have any serious eye injury, disease, or surgery? ______ If yes, describe the condition(s) and date(s) of occurrence____
____
____

List any family members with glaucoma: ____
List any family members with macular degeneration: _____________________________________
List any family members with retinal detachment: ____
List any family members with strabismus (eye turn): ____________________________________
List any family members with amblyopia (lazy eye):______________________________________
Any other eye disease that runs in your family? ____
____

Are you currently experiencing any *vision* problems? ______ If yes, describe_________________
____
____
Are you currently experiencing any other problems with your eyes, such as dryness, itching, redness, double vision, increased light sensitivity, etc.? _____ If yes, describe: ________________
____

What is the primary reason for your visit today? ____
____
Do you have any concerns or questions not mentioned above? ______________________________
____

Thank you for choosing Malvern Eye Care!