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: _____Age:____ 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: _____
Vision ID Number:_____Do you have Vision Benefits?_____Name of Vision Insurance
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!