Medical & Surgical Eye Specialists, Inc.

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Chesapeake, Virginia 23320
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PATIENT REGISTRATION

Patient Name				**Salutation**	
Birthdate		**Age**		**Birth State**	
Sex				**SS #**	
Address					
Address Type				**Country**	

COMMUNICATION					
Preference					
Home Phone #		**Work Phone #**		**Extension**	
Cell Phone #		**Carrier**			
Email					

INFORMATION			
Plan Type		**HIPAA Signed**	
Primary Language		**Special Needs**	
Race		**Ethnicity**	
Marital Status		**Mother's Maiden Name**	
Occupation		**Employer**	

ACCOUNT RESPONSIBLE **(If the patient is a minor, please complete this section)**					
Responsible				**Salutation**	
Relationship				**SS #**	
Address					
Home Phone #		**Work Phone #**		**Extension**	
Email					

PRIMARY INSURANCE			
Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Copay			
Insured		**Date of Birth**	

SECONDARY INSURANCE			
Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Copay			
Insured		**Date of Birth**	

INSURANCE INFORMATION (if already listed above you may skip or use to correct insurance information)			
Name		**Group Name**	
ID #		**Group #**	
Address			
Phone			
Copay			
Insured		**Date of Birth**	

EMERGENCY CONTACT										
Sal	**First**	**MI**	**Last**	**Relation**	**Home#**	**Cell#**	**Work#**	**Ext**	**Organization**	**Title**

OTHER CONTACTS										
Sal	**First**	**MI**	**Last**	**Relation**	**Home#**	**Cell#**	**Work#**	**Ext**	**Organization**	**Title**

RELEASE OF MEDICAL INFORMATION – STATUS				
	Relation		**Release Status**	

If not listed above please complete the following information
EMERGENCY CONTACT:

Name: _____ **Telephone Number:** _____

Relationship: _____ **Sex:** _____

Is this person allowed access to you medical information? **Yes** ☐ **No** ☐

Who is your Medical Doctor (PCP): _____

Reason for your visit today: _____

Please list your Current Medications:

Please list any surgeries you have had and dates:

Review of Systems:	
General Symptoms (Fever, Weight Loss, Fatigue...)	
Eyes/Vision: (Blurred, Redness, Pain, Double Vision, Discharge, Glare, Haloes, Itchy, Watery)	
Cardiovascular: (Chest Pain, Palpitations)	
Ears, Nose, Mouth, Throat (Hearing Loss, Nasal Congestion)	
Respiratory: (Shortness of Breath, Cough)	
Gastrointestinal: (Heart Burn, Indigestion)	
Genitourinary: (Frequent Urination, Discolored Urine)	
Musculoskeletal: (Sore Muscles, Joint Pain)	
Integumentary: (Skin rash, Itchy Skin)	
Neurological: (Weakness, Poor Memory)	
Psychiatric: (Depression, Mood Swings)	
Endocrine: (Hot Flashes, Excessive Thirst)	
Hematologic/Lymphatic: (Easy Bruising, Swollen Lymph Nodes)	
Allergic/Immunologic: (Hay Fever, Frequent Colds)	
Other Diseases or Issues not listed:	

Past, Family and Social History: (Please check all that apply)

Condition	You	Family	Condition	You	Family
Cataracts			High Blood Pressure		
Glaucoma			Diabetes		
Crossed Eyes			High Cholesterol		
Lazy Eye			Heart Attack		
Macular Degeneration			Stroke		
Other Eye Disease			Congestive Heart Failure		
Rheumatoid Arthritis			Asthma		
Lupus			Emphysema		
Sarcoidosis			Tobacco Use		
Thyroid Disorder			Drink Alcohol		
Cancer or Tumors			HIV/AIDS		

AUTHORIZATION FOR MEDICAL CARE AND NOTICE OF PRIVACY PRACTICES

I hereby authorize treatment to the patient by the physician and/or staff of Medical & Surgical Eye Specialists. This authorization specifically includes the use of dilating eye drops which will result in temporary blurred vision. I also authorize release of any medical information necessary to process the insurance, and I authorize direct payment to Medical & Surgical Eye Specialist, Inc. I accept responsibility for payment of all charges incurred, as well as attorney and collection fees of 33.33% should such action become necessary. By my signature, I also acknowledge that I have received a copy of and read the Medical & Surgical Eye Specialists ' Summary Notice of Privacy Practices.

Signature: _____ Date: _____