Medical & Surgical Eye Specialists, Inc.

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Patient Registration

Patient Information

Patient Name (First, Middle, Last)	Suffix (Jr.,Sr.)	Salutation (Mr.,Ms.)	Nickname	Date of Birth	Today's Date	Social Security #	Birth State	Sex	Age

Address	Address Type (Home, Billing Address, Office/Business)	Country

Home Phone	Cell Phone	Work Phone / Ext	Email Address	Preferred Communication (Cell, Email)

Preferred Local Pharmacy	Preferred Mail Order Pharmacy

Primary Language	Special Needs	Marital Status	Maiden Name	Mother's Maiden Name	Plan Type

Race	Race 2	Ethnicity	Ethnicity 2

Employer	Occupation

Responsible Party Information

Patient's Relationship to the Responsible Party (Self, Spouse, Child)

Responsible Party's Name (Salutation, First, Middle, Last)	Date of Birth	Home Phone	Cell Phone	Work Phone / Ext

Address (Street, City, State, ZIP)	Email Address	Social Security #	Gender

Primary Insurance

Insured's Name	Date of Birth	ID Number

Insurance Company Name	Insurance Co. Phone

Insurance Company Address	PAY %

Group Name	Group Number	Copay

Secondary Insurance

Insured's Name	Date of Birth	ID Number

Insurance Company Name	Insurance Co. Phone

Insurance Company Address	PAY %

Group Name	Group Number

Contacts

Name/ Relationship/ Address	Title/ Specialty	Emergency Contact	Release Medical Info	Phone Numbers/ Fax

Medical and Family History: (Please check all that apply)

Condition	You	Family
Cataracts	☐	☐
Glaucoma	☐	☐
Crossed Eyes	☐	☐
Lazy Eye	☐	☐
Macular Degeneration	☐	☐
Other Eye Disease	☐	☐
Rheumatoid Arthritis	☐	☐
Lupus	☐	☐
Sarcoidosis	☐	☐
Thyroid Disorder	☐	☐
Cancer or Tumors	☐	☐

Condition	You	Family
High Blood Pressure	☐	☐
Diabetes	☐	☐
High Cholesterol	☐	☐
Heart Attack	☐	☐
Stroke	☐	☐
Congestive Heart Failure	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Tobacco Use	☐	☐
Drink Alcohol	☐	☐
HIV/AIDS	☐	☐

Medications:

Allergies:

Primary Care Provider:

Other Referring Doctor (name and specialty):

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.

Today I will be using (pick one): ☐ **medical insurance** ☐ **vision insurance (e.g.,VSP, EyeMed, Superior)**

Signature: Date: