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Patient Registration Form

Personal Information

Patient Name (Please Print): _____
Last First MI

Date of Birth: ____/____/_____ **Birth Sex:** _____ **Social Security #:** _____

Race:

- ☐ White
- ☐ Black/African American
- ☐ Asian American
- ☐ Hispanic or Latino
- ☐ Somali
- ☐ Other: _____

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Decline to specify
- ☐ Other: _____

Preferred Language:

_____

Please list communication needs:

_____

Contact Information

Address: _____
Street City State Zip Code

Home: (____)_____ Message? Yes or No **Cell:** (____)_____ Message? Yes or No

Email: _____

Notification for appointments: ☐ Home ☐ Cell ☐ Email ☐ Text

Employment Information

Employer: _____ **Phone:** (____)_____

Emergency Contact Information

Name: _____ **Phone:** (____)_____

Name: _____ **Phone:** (____)_____

Please list names and relationship of individuals we may release medical information

Name: _____ **Relationship:** _____

- ☐ Entire Record

***OR** check only items that can be disclosed:*

- ☐ Office Notes
- ☐ Lab/Pathology results, Testing
- ☐ Finances
- ☐ Record of HIV and communicable diseases
- ☐ Record of mental health and substance abuse
- ☐ Other:_____

Name: _____ **Relationship:** _____

- ☐ Entire Record

***OR** check only items that can be disclosed:*

- ☐ Office Notes
- ☐ Lab/Pathology results, Testing
- ☐ Finances
- ☐ Record of HIV and communicable diseases
- ☐ Record of mental health and substance abuse
- ☐ Other:_____

Privacy Policy

_____(Initial) I have read or received a copy of the Notice of Privacy Practices for Ophthalmology Associates & LASIK Center.

I agree that the above information is accurate and understand this form will be updated yearly. I will update Ophthalmology Associates & LASIK Center when information changes prior to a year.

Patient/Guardian Signature: _____ Date: _____