Prime Eye Care Specialists, Inc.
www.PrimeEyeCareSpecialists.com

Patient Registration Form

PATIENT INFORMATION	
NAME	PRIMARY CARE PHYSICIAN
DOB [ ] MALE [ ] FEMALE	REFERRING PHYSICIAN
ADDRESS	OPHTHALMOLOGIST/OPTOMETRIST
CITY STATE ZIP	PREFERRED PHARMACY
PHONE E-MAIL:	EMERGENCY CONTACT / RELATIONSHIP TO PATIENT / PHONE NUMBER

FINANCIAL INFORMATION	
PRIMARY INSURANCE	PRIMARY INSURANCE POLICY NUMBER
PRIMARY INSURED NAME (IF OTHER THAN PATIENT)	PRIMARY INSUSURED RELATIONSHIP TO PATIENT
SECONDARY INSURANCE	SECONDARY INSURANCE POLICY NUMBER
SECONDARY INSURED NAME (IF OTHER THAN PATIENT)	SECONDARY INSURED RELATIONSHIP TO PATIENT

MEDICAL & EYE HISTORY: Please list all medical/eye conditions	**SURGICAL HISTORY:** Please list any surgeries and the year
1.	1.
2.	2.
3.	3.

DO YOU SMOKE?	DO YOU CONSUME ALCOHOL?
[ ] YES: HOW MANY CIGARETTES PER DAY? _____ [ ] NO: [ ]NEVER SMOKED [ ]QUIT IN (YEAR):_____	[ ] YES: HOW MANY DRINKS PER WEEK? _____ [ ] NO

7345 Medical Center Drive, Suite 320, West Hills, CA 91307 • Phone (818) 953-0093 • Fax (877) 883-9992
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ALLERGIES	FAMILY HISTORY: List medical problems that run in your family
1.	1.
2.	2.
3.	3.

CURRENT MEDICATIONS AND EYE DROPS	
1.	4.
2.	5.
3.	6.

INFORMATION REGARDING DILATING DROPS
Dilating drops are used to dilate and enlarge the pupils of the eye to allow the physician to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which may last a couple of hours, but may last longer depending on the individual. Dilating drops may also make bright lights bothersome. It is not possible for the physician to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it is best if you make arrangements not to drive yourself. Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention. My signature below additionally authorizes, my designated care giver to administer dilating eye drops, which is necessary to diagnose my condition.
NOTICE OF PRIVACY PRACTICES AND REASSIGNMENT OF BENEFITS
I have had the opportunity to review the Prime Eye Care Specialists notice of privacy practices. I hereby also authorize Medicare and/or any other insurance company to make payment directly to my physician for services rendered. I also authorize Prime Eye Care Specialists to release any of my protected health information to any insurance carrier (payor), for the purposes of determining healthcare benefits and making payment for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment.

SIGNATURE AUTHORIZATION	
SIGNATURE	DATE
PRINTED NAME	

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