Patient Registration-Northern Avenue Eye Care

( ) Male ( )Female Today's Date ________ / ________ / ___________

Mr/Mrs/Ms/Miss ____
Last First MI Spouse

Local Address ____
Street Apt# City State Zip

Mail Address ____
Street Apt# City State Zip

Phone: Home ___________________ Work _______________ Other ___________________________

Email Address____________________ @ __________ Social Security # __________ / __________ / ____________
(Necessary for some insurance)

Age: _______________ Date of Birth ________ / ________ / ____________

Responsible Party ____
Last First MI Phone Relationship

Employer ____
Name Address City State Zip Occupation

Emergency Contact ____
(Not in same household) Name Phone Relationship

Medical Information:
Medical Doctor ____
Name Address City State Zip Phone

Insurance Information:
Primary Insurance Co.____
Name Policy Holder DOB Group# Policy#

Primary Address ____
Street City State Zip Phone

Secondary Insurance ____
Name Policy Holder DOB Group# Policy#

Secondary Address ____
Street City State Zip Phone

Authorization and Release:
I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company and/or Medicare to pay directly to the doctors or doctor's group insurance or Medicare benefits otherwise payable to me.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also understand that I will be billed a fee for any returned checks.

________________________________ ______ / ______ / ________ ______________________________
Signature of patient or parent, if minor Date Signature of witness

How were you referred to our office?

Doctor ______________________________ Friend or Relative ______________________________
Name Name

Newspaper Radio/Television Screening Yellow Pages Reputation Insurance List

Other ______________________________

Visit our website: www.northernaveeyecare.com

Northern Avenue Eye Care ☼ 2337 West Northern Ave ☼ Phoenix, AZ 85021
Phone 602.995.8848 ☼ Fax 602.995.2980

Patient History-Northern Avenue Eye Care

Thank you for completing this form. The information will assist the doctors and staff in providing quality care.

Mr/Mrs/Ms/Miss Last First MI DOB Today's Date

Medical History: Do you have or have you had:

Lung	Yes	No	Family	**Vascular**	Yes	No	Family
Asthma	O	O	O	Congestive heart failure	O	O	O
Bronchitis	O	O	O	Heart attack	O	O	O
Emphysema	O	O	O	Heart disease	O	O	O
Pneumonia	O	O	O	High blood pressure	O	O	O
				Stroke	O	O	O
Systemic	Yes	No	Family	**Other**	Yes	No	Family
Anemic	O	O	O	Cancer	O	O	O
Bleed Disorders	O	O	O	Glaucoma	O	O	O
Sickle Cell	O	O	O	Hepatitis	O	O	O
Clot Disorders	O	O	O	Seizures	O	O	O
Arthritis	O	O	O	Pregnant	O	O	Weeks ________
Diabetes	O	O	O				
Thyroid	O	O	O				

Any other diseases, conditions or problems we should know about?

Surgery History: List **ALL** prior surgeries with years:

________________________________ Date___________ ________________________________ Date___________

________________________________ Date___________ ________________________________ Date___________

________________________________ Date___________ ________________________________ Date___________

Have you or anyone in your family had problems with previous anesthetics: Yes No If yes, please explain:

Social History: Do you smoke? Yes No Packs per day? ___ How many years? ___ Alcoholic beverage use? Yes No

Medications:

Drug name	Strength	How often is medication used

Allergies: List all medications, foods and soaps you are allergic to. If none state **NONE**.

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