MOUNTAIN EMPIRE EYE PHYSICIANS
An AVP Company

NEW PATIENT REGISTRATION

MR / MRS / MS _____
Last Name First Name Middle Initial Sex Date of Birth

_____
Address City State Zip Social Security No.

_____ (Single/Married/Divorced/Widowed/Separated)
Home Phone Alternate Phone (Cell/Work) Marital Status - Circle One

RESPONSIBLE PARTY

_____
Name Home Phone Work Phone

_____
Address City State Zip

INSURANCE

_____
Primary Insurance Number Effective Date

_____
Subscriber Name Relationship

_____
Subscriber Date of Birth Subscriber Social Security No.

_____
Secondary Insurance Number Effective Date

_____
Subscriber Name Relationship

_____
Subscriber Date of Birth Subscriber Social Security No.

EMERGENCY CONTACT

_____
First Name MI Last Name Phone Relation

_____
Address City State Zip

INSURANCE AUTHORIZATION, ASSIGNMENT AND REFERRAL

I consent to treatment necessary for the care of the above-named patient. If registering a minor, I certify that I am the child's custodial parent or legal guardian. I authorize Atlantic Vision Partners (AVP) to furnish information, generate referral letters and release all medical records to the referring and personal physicians and to my insurance carriers including the Social Security Administration or its intermediaries, concerning my illness and treatment. I permit fax and electronic transmission of my medical records. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party that accepts the assignment. I understand that insurance is a contract between my insurance company and me that any filing of insurance by AVP is a courtesy only. I am fully responsible for obtaining and delivering any applicable referrals. I authorize and request that insurance payments be made directly AVP should they elect to receive such payments.

I understand that payment of all charges incurred is due at the time of service. I acknowledge full financial responsibility for services rendered by AVP. I understand that I am financially responsible for any outstanding balances. In the event of default on any payment due, I agree to pay all costs of collection, including attorney fees of 30% on the amount due at the time of default. I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

_____
Signature Date

MOUNTAIN EMPIRE EYE PHYSICIANS
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Name _____ Date of Birth _____
Referred by: _____ Last Eye Examination _____

Explain the ***specific reason*** for your visit today:

_____

_____

YOUR EYE HISTORY **EXPLANATION AND DATE**

( ) Injury ( ) Tumor _____
( ) Surgery ( ) Crossed Eye _____
( ) Cataract ( ) Lazy Eye _____
( ) Glaucoma ( ) Retina Problems _____
( ) Other _____

YOUR MEDICATIONS - Please attach if the list is longer than space available.

FOR YOUR EYES	ALL OTHER MEDICATIONS

MEDICINE ALLERGIES and other allergies

_____

ALL SURGERY - TYPE AND DATE

_____

_____

MEDICAL HISTORY **EXPLANATION AND DATE**

( ) Diabetes ( ) Cancer _____
( ) High Blood Pressure ( ) Stroke _____
( ) Heart Disease ( ) TB _____
( ) Thyroid Condition ( ) Other _____
( ) AIDS/HIV/Hepatitis ( ) **NONE** _____

FAMILY EYE HISTORY **EXPLANATION - WHICH RELATIVE**

( ) Glaucoma ( ) Diabetes _____
( ) Crossed Eye ( ) Eye Cancer _____
( ) Cataract ( ) Other _____
( ) Retina Problems ( ) **NONE** _____

WHO IS YOUR (PCP) PRIMARY CARE PHYSICIAN/PEDIATRICIAN? **Your Doctor's Phone Number**

_____ _____

WHO MAKES YOUR EYE GLASSES? _____

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Review of Systems

For each section, please CIRCLE any conditions that apply. Circle "NONE" if none applies. Add additional notes if you wish.

GENERAL / CONSTITUTIONAL

Weight loss or gain
Fever / chills
Trouble sleeping
Fatigue
Weakness
NONE

SKIN

Rash or itch
Hair or nail changes
Suspicious growth
Color changes
Dryness
NONE

EAR / NOSE / THROAT / MOUTH

Decreased hearing
Ringing in ears
Vertigo
Discharge
Hay fever
Sinus problems
Bleeding teeth / gums
Sore throat / tongue
Non-healing sores
Use hearing aids
Earache
Stuffiness
Itching
Nosebleeds
Dentures
Dry mouth
Hoarseness
NONE

LUNGS / RESPIRATORY

Cough
Shortness of breath
Painful breathing
Coughing of blood
Wheezing
NONE

HEART / CIRCULATION

Chest pain
Palpitations
Calf pain with walking
Leg cramping
Chest tightness
Leg swelling
NONE

DIGESTIVE

Swallowing difficulties
Change in appetite
Change in bowel habits
Constipation
Hiatal hernia
Heartburn / Acid Reflux
Nausea
Rectal bleeding
Diarrhea
NONE

NEUROLOGICAL

Dizziness
Seizures / fainting
Numbness / tingling
Decreased memory
Weakness
Tremor
Disorientation
NONE

URINARY / GENITAL

Change in urinary strength/ frequency / urgency
Pain w/intercourse
Blood in urine
Masses / pain
Vaginal dryness
Repeat yeast infections
Burning or pain
Incontinence
Discharge or sores
Erectile dysfunction
Itching or rash
Hot flashes
NONE

MUSCLES / BONES

Muscle or joint pain
Back pain
NONE
Stiffness
Redness o f joints
Swelling of joint

ENDOCRINE / GLANDS

Heat / cold intolerance
Frequent urination
Change in appetite
NONE
Sweating
Excessive thirst
Yellow eyes / skin

BLOOD SYSTEM

Ease of bruising
History of transfusion
NONE
Ease of bleeding
Anemia

MENTAL HEALTH

Anxiety
Memory less
NONE
Depression
Stress
Hallucinations

ALLERGY / IMMUNE SYSTEM

Environmental allergies
Medicine allergies
TB (tuberculosis)
NONE
Food allergies
Reduced immunity
Hepatitis
HIV / Aids

TOBACCO / ALCOHOL

TOBACCO: Current Former Never
ALCOHOL: Often Occasional No

Print Name _____

Signature _____

Date _____