PATIENT REGISTRATION FORM

NAME ____ DATE OF BIRTH______________

ADDRESS____ CITY______________________________

STATE______________ ZIP CODE_____________________ OCCUPATION_________________________

PHONE: (HOME)__________________ (CELL) ______________________(WORK)___________________

EMPLOYER____________________________ ADDRESS____________________________________

SPOUSE OR PARENT__________________________ email __________________________________

EMPLOYER ____(WORK PHONE)______________

REFERRED BY____

PLEASE LIST OTHER FAMILY MEMBERS THAT HAVE BEEN HERE

NAME RELATIONSHIP DATE OF BIRTH

1.____

2.____

To hold down fees, we appreciate payment for your exam on the day of your exam. For contact lenses or glasses, we require half down payment to order and the balance on pickup.

Race :				**Preferred Communication:**	
African American	☐	Hawaiian/Pacific	☐	Phone	☐
American Indian/Alaskan	☐	Hispanic	☐	Mail	☐
Asian	☐	Other	☐	Email	☐
Caucasian	☐				

Authorization to release:

Our Privacy Practices provides information about how we may use and disclose information about you to carry out treatment, payment and healthcare operations. You have the right to review the Patient Rights before signing. By signing, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this consent in writing. Also by signing this consent, you are authorizing your insurance company to pay directly to our office and you realize you are responsible for any fees not covered by your insurance company.

Signed ____ Date___________________________

Relationship to patient ____________________________________

Patient Rights:

Effective April 14, 2003; the federal government set a law in place to protect you and the release of your medical information. We at the office of Dr. Orr and Dr. Routledge, promise to do our part in upholding this law. Our office is permitted by federal laws to make uses and disclosures of your health information for purposes of treatment, payment and healthcare operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examinations, test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.. I have read the information regarding Federal Privacy Law and understand my rights as a patient of Dr. Orr and Dr. Routledge.

Signed ____ Date___________________________

Relationship to patient ____________________________________

A COPY OF THE FEDERAL PRIVACY LAW IS AVAILABLE TO YOU AT YOUR REQUEST.