

SIMPSON EYE ASSOCIATES, LTD. PATIENT REGISTRATION FORM

(Please Print)

HOW DID YOU HEAR ABOUT SIMPSON EYE ASSOCIATES (please check one box):

<input type="checkbox"/> Billboard	<input type="checkbox"/> Our Employee	<input type="checkbox"/> Employer	<input type="checkbox"/> Friend	<input type="checkbox"/> Insurance	<input type="checkbox"/> Internet	<input type="checkbox"/> Medical Doctor	
<input type="checkbox"/> Hospital (Which one)	<input type="checkbox"/> Emerg. Room (which one)	<input type="checkbox"/> Centegra/ NIMC	<input type="checkbox"/> Centegra / Woodstock	<input type="checkbox"/> Good Shepherd	<input type="checkbox"/> Mercy	<input type="checkbox"/> Sherman	<input type="checkbox"/> St. Joseph
<input type="checkbox"/> Newspaper	<input type="checkbox"/> Optometrist (Who):		<input type="checkbox"/> Relative	<input type="checkbox"/> Screening	<input type="checkbox"/> Sign-Drive By		
<input type="checkbox"/> Sun City	<input type="checkbox"/> Work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other (tell us):				

Other family members seen here:

Today's Date:

PATIENT INFORMATION

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Dr.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Rev.	Patient's last name:		First:	Middle:
Birth Date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: - -	
Street			City:	State:	Zip:
Home phone no.: ()			Mobile or other phone no.: ()		
Employer:			Occupation:	Work phone no.: ()	
Employer address:			Is this exam a workers compensation claim? <input type="checkbox"/> Yes <input type="checkbox"/> No	Contact name:	
Insured's last name:		First:	Middle:	Relationship to Insured:	
Insured's employer: <input type="checkbox"/> Same as Above		Retired: <input type="checkbox"/> Yes <input type="checkbox"/> No	Insured's work phone no.:		
Insured employer's address:			Insured's date of birth: / /	Insured's social security no.: - -	
Patient's spouse or Parent (if minor):				Spouse's employer:	
Last:		First:	Middle:		
Are you here at the request of legal counsel, or for examination related to a lawsuit or legal event? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Primary Care Physician:		First name:	Last Name:	<input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> O.D.	
Physician's Phone: ()			Physician's Address:		

IN CASE OF EMERGENCY

Name of local friend or relative	Relationship to patient:	Home phone no: ()	Work phone no: ()
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The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Simpson Eye Associates or my Insurance Company(s) to release any information required to process my claims. I authorize the release of any medical information necessary to process all claims and I authorize the release of information to my referring physician or primary care physician.

Patient /Guardian Signature

Date

DILATION PATIENT INFORMATION

During the course of your examinations at Simpson Eye Associates, it is likely that your eyes will be dilated with medications. This process allows the ophthalmologist to see into the back of your eye(s). It is a necessary part of the process in order to provide a comprehensive examination. The dilation process is pain-free. However the side effects include blurred near vision which can last several hours (4-6 hours). In children the dilation drops are a bit stronger and will last longer. If you believe that your ability to drive has been impaired we strongly recommend that you have a driver pick you up.

In the future please be aware that appointments with one our physicians will likely include dilation.

Patient/Guardian Signature

Date

