Chris R. Rand, O.D., P.A. **New Patient Registration Form**

Patient Info:

Name ______________________________________ Today's Date ________________________________

Address ____________________________________ Date of Birth _____________________ Age________

City _______________ State _______ Zip ________ Social Security #_______________________________

Sex M F Marriage Status Single Married Divorced

Email Address________________________________ Home Phone _________________________________

Employer ___________________________________ Cell Phone __________________________________

Occupation _________________________________ Work Phone__________________________________

Emergency Contact ____________________________ Contact Phone _______________________________

Information of Insured/Responsible Party:

Insurance Company ____________________________ Member # ___________________________________

Name of Insured ______________________________ Relationship Self Spouse Parent Guardian

Address ____________________________________ Date of Birth ________________________________

City _______________ State________ Zip _________ Social Sec# __________________________________

Employer ___________________________________ Phone ______________________________________

Secondary Insurance____________________________ Member # ___________________________________

Name of Insured ______________________________ Relationship Self Spouse Parent Guardian

Address ____________________________________ Date of Birth ________________________________

City _______________ State________ Zip _________ Social Sec# __________________________________

Employer ___________________________________ Phone ______________________________________

I hereby consent to treatment by Chris R. Rand, O.D. I authorize the release of my medical information to my insurance carrier, governmental agency or its intermediary, any information needed for this or any related insurance claim. If correct information is not provided at the time of service and my insurance carrier denies payment as a result, I understand I am responsible for the full payment of denied claim.

Signature of Patient/Parent or legal guardian ____________________________ Date ____________________

Medical Information

Date ____________________________ Referred by ______________________

Name ___________________________ Family Physician _________________

Past History

1) Medication Allergies:

2) Past Medical History:

3) Past Surgical History:

4) Current Medications: (Name & Purpose)

Family History of:

Cataracts ________________________ Diabetes ________________________

Glaucoma _______________________ High Blood Pressure_______________

Retinal Detachment _______________ Heart Disease ____________________

Eye Disorders ____________________ Other ___________________________

Current Eye Problem

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HIPPA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgment Form

Chris R. Rand, O.D., P.A.

Acknowledgment of receipt of Information Practices Notice (164.520(a))

I, ____________________________ (Patient's Name) understands that as part of my health care, Chris R. Rand, O.D., P.A. originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Chris R. Rand, O.D., P.A. **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review Chris R. Rand, O.D., P.A. Notice of Privacy Practices prior to signing this acknowledgment;
- That Chris R. Rand, O.D., P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation of the will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness ______________________________________

Printed Name of Individual or Legal Representative Witness __________________________________

Date__________________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Others (please specify)

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Mrs. Kim Cook Date
Privacy Official