MITCHELL & MORIN
EYE INSTITUTE

DATE: _____

ADS ACCOUNT # (internal use only): _____

REGISTRATION FORM

PLEASE PRINT LEGIBLY

LAST NAME: _____

FIRST NAME: _____ **MIDDLE INT:** _____

SOCIAL SECURITY #: _____-_____-_____ **BIRTHDATE:** _____ - _____ - _____

SEX: _____ **MARITAL STATUS:** _____

STREET ADDRESS (INCLUDE APT#): _____

CITY: _____ **STATE:**_____ **ZIPCODE:** _____

HOME PHONE: ( )_____ **WORK PHONE: ( )**_____

CELL: ( ) _____ **FAX: ( )** _____

EMAIL: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

EMPLOYER CITY: _____ **ST:**_____ **ZIP:**_____

EMERGENCY CONTACT PERSON: _____ **PHONE:** _____

RELATIONSHIP TO PATIENT: _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____

REFERRING DOCTOR: _____

HOW DID YOU HEAR ABOUT US?:_____

_____

_____

Mitchell Eye Institute, P.C.
Clinical History Form

PATIENT NAME:_____ DATE:_____

In an effort to spend as much quality time with you during your exam as possible, we would appreciate you filling in as much of the following information as possible while you are waiting OR before you arrive.

CURRENT MEDICATIONS **Dose** **Reason for taking it**

_____

_____

_____

_____

_____

CURRENT PHARMACY:_____LOCATION_____PHONE#_____

Your height? _____ Current weight? _____Most Recent Blood Pressure ?_____

Do you smoke? _____ If you used to, when did you quit? _____

Do you have any medical conditions or have you had any surgery? (use reverse side if necessary)

_____

_____

_____

Please check if you are experiencing any of the following symptoms:

Fever: _____ Weight Loss: _____ Fatigue: _____ Headaches: _____ Sinus Congestion: _____

Ear/Balance problems: _____ Cough: _____Chest pain: _____ Shortness of Breath:_____

Abdominal pain: _____ Vomiting: _____ Difficulty Eating: _____ Nausea: _____

Arthritis: _____ Rashes: _____ Weakness:_____ Depression or Psychological problems:_____

Confusion: _____ Hormonal Problems: _____ Bleeding or clotting problems: _____

MEDICATION ALLERGIES:_____

_____

FAMILY HISTORY OF EYE PROBLEMS?_____

RACE:_____ ETHNICITY: _____ PREFERRED LANGUAGE:_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

Mitchell Eye Institute, P.C.
8218 Wisconsin Ave, Suite P-10
Bethesda, Maryland 20814

Mitchell Eye Institute, P.C.
130 Park Street SE, Suite 300
Vienna, Virginia 22180

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

The posted *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information. I understand that this organization had the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME: (PRINT) _____

PATIENT SIGNATURE: _____

Date: _____

GUARDIAN NAME/SIGNATURE: _____

Relationship to Patient: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgment of the Notice of Privacy Practices, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____