Patient Registration Form

Welcome to our office. Please complete this form and return it to the receptionist.

❑ Mr. ❑Mrs. ❑Miss ❑Ms. ❑Dr. ❑Single ❑Married ❑Widowed ❑Divorced

Name: ______________________________________ M F Date: ______________

First Middle Last

Address: ____

Number & Street Apt/Unit City & State Zip

Home Phone: ________________ Work: _________________ Cell: __________________

Date of Birth: ______________________ Social Security No:_________________________

E-Mail Address: ____

For appointment confirmation only. We will not share your email with any outside agency.

Occupation/Employer: ____

If Patient is a Minor – Responsible Party: ____

First Last Relationship

Emergency Contact: ____________________________ Phone: ________________________

Address: ____________________________ Relationship: ___________________

Who is your primary care physician:

Primary Medical Doctor: ________________________ Phone: _________________________

Address: ____

Number & Street Floor/Suite City & State Zip

Preferred Pharmacy:

Name:____________________City:________________________ Ph:________________

REFRACTION IS THE PART OF THE EYE EXAM THAT WILL DETERMINE WHETHER YOU CAN BE HELPED WITH NEW GLASSES OR CONTACTS LENSES. IT IS NOT A COVERED SERVICE BY MEDICARE AND MOST MEDICAL INSURANCE PLANS. PLEASE INDICATE IF YOU WISH TO HAVE THIS SERVICE DONE:

Glasses prescription :
$50 fee

Contact Lenses:
$125 first time fee $75 refit fee

➔*TURN*➔

EYE CARE OF RIVER EDGE
Marta Ponce-Contreras M.D.
(201) 489-0096
1060 Main St. Suite 301, River Edge, NJ 07661

Acknowledgment of Notice of Privacy Practice

Today's Date:______________________________ Is Patient a minor? Yes No

Patient's Name:______________________________ Date of Birth: _________________________

PRIVATE HEALTH INFORMATION (PHI) TO BE DISCLOSED

_____ Release information as described in the Notice of Privacy Practices

_____ I allow the following individuals to speak to you/obtain information about my medical condition.

FULL NAME OF INDIVIDUAL (not including medical doctors) Relationship

____

____

____

Please tell us about any restrictions you have on the release of information to the above listed people:

____

____

Please check mark all options that apply:

_____**DO NOT** leave message on machine regarding appointment times, insurance information, etc.

_____**OK** to leave message on machine regarding appointment times, insurance information, etc.

_____**DO NOT** release any information regarding appointment times, insurance information, etc. to any family member

_____**OK** to release any information regarding appointment times, insurance information, etc. to any family member

TERM

This information will remain in effect from the above date and will remain in force unless I submit a change request in writing.

PATIENT ACKNOWLEDGEMENT

I acknowledge that I have been given the opportunity to review the Notice Of Privacy Practices detailing how much health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information. If patient is a minor, or otherwise unable to sign, an authorized representative should sign below.

______________________________ ______________________________

Patient Signature (or Authorized Representative) Print Name (Authorized Representative)

Relationship to Patient (Authorized Representative)

____