

PATIENT REGISTRATION
Tomoka Eye Associates

OFFICE USE ONLY

Dr. _____
Appt. _____

Referred By: _____
(If your insurance requires a referral, please bring it with you)

Patient Name: _____ Nickname: _____
 First Middle Last

Date of Birth: ____/____/____ Social Security # ____-____-____

Local Mailing Address _____ Email address: _____

City _____ State _____ Zip Code _____

Other Address _____

City _____ State _____ Zip Code _____

Home Phone# _____ Cell Phone# _____ Alternate Phone# _____

Sex (circle) **M F** Marital Status (circle) **M D S W** Spouse's Name: _____

Retired? (circle) **N Y** Employer: _____ Phone# _____

Who, other than your spouse, do we call in case of an emergency? Name: _____

Relationship: _____ Phone # (s) _____

Do you give permission to Tomoka Eye Associates to advise family members of medical status? (circle) **Y N** Please list names and relationship: _____

Please read and initial the following policies:

TOMOKA EYE ASSOCIATES HIPAA POLICY: Effective 4/14/2003

I have received and understand the HIPAA Privacy Policy for Tomoka Eye Associates/Tomoka Optical. Initials _____

TOMOKA EYE ASSOCIATES REFRACTION POLICY:

In Ophthalmology, the **refraction** is a clinical test used to determine the eye's refractive error and the best corrective lenses to be prescribed. This is a necessary part of the medical exam to provide the sharpest, clearest vision. In most cases, the **refraction** is required for continuation of care. The fee for the refraction is \$30.00 and may not be covered by your insurance company (including Medicare). I understand the refraction charges. Initials _____

I verify the information provided is true and accurate. I understand it is my responsibility to notify Tomoka Eye Associates of any changes to the information provided.

Signature: _____ Date: _____

Relationship if signed by other than patient: _____ Reason unable to sign: _____