

New Era Eye Care

Date: _____

Patient Name: _____ Guarantor: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____ Marital Status: _____

Phone No.: (_____) _____ Social Security #: _____ - _____ - _____

eMail Address*: _____ Sex: M F

*The email address will be used as your login ID to gain access to your exam and treatment information via the secure patient portal.

Check here if you also wish to receive our office newsletters and promotional offers via this email address.

Referred by: _____ Doctor: _____

Employer: _____ Employee Type: Full-time Part-time Retired Unemployed

Address: _____ City _____ St. _____ Zip: _____

Patient Record Uses and Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means such as sending correspondence to the individual's office instead of the individual's home.

Home Phone Number: _____

_____ Detailed message can be left

_____ Leave message with call-back number only

Other Phone Number: _____ Cell Work Other: _____ (circle one)

_____ Detailed message can be left

_____ Leave message with call-back number only

Written Communication:

_____ Correspondences can be mailed to my home address

_____ Correspondences should be mailed to the following address:

People to whom your Medical Information can be disclosed if requested (i.e. Doctor, Spouse, Parents):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____