MINNESOTA EYE CONSULTANTS, P.A.

OFFICE USE ONLY
PN: _____
DOS: _____

REGISTRATION FORM

Patient Information

Last Name: _____ **First Name**: _____ **MI**: ___

Nickname: _____ **SSN:** _____

Birth Date: _____ **Sex**: ☐ Male ☐ Female

Address: _____
STREET CITY / STATE / ZIP

Home Phone: _____ **Alternate Phone**: _____

Cell Phone: _____ **E-Mail**: _____

Preferred Language: _____ **Interpreter Required**? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Other: _____

Emergency Contact: _____

Phone Number: _____ Relationship: _____

Referring Provider: _____ **Primary Care Provider**: _____

Clinic: _____ Clinic: _____

How did you hear about Minnesota Eye Consultants (check all that apply)?

☐ Referring Provider: _____ ☐ Word of Mouth: _____
☐ Television / Radio: _____ ☐ Internet: _____
☐ Mailing: _____ ☐ Magazine / Newspaper: _____
☐ Event / Exhibit: _____ ☐ Other: _____

Cultural Background Information

Federal healthcare programs require that we collect and report patient race and ethnicity data in an effort to identify and improve healthcare disparities among various racial / ethnic groups. This information is confidential, and will not impact your care at Minnesota Eye Consultants. Your response is voluntary, and you may select “Decline to Specify”.

Race (select as many that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Decline to Specify

Ethnicity (select one)

☐ Hispanic or Latino
☐ Non-Hispanic or Latino
☐ Decline to Specify

MyMEC Patient Portal
The patient portal is a convenient and secure way to access your health information, as well as communicate with your eye care team. If you are not yet enrolled, we will complete your enrollment at the time of your appointment. You will receive instructions to complete registration to participate in the patient portal when enrollment has been completed. Participation is encouraged but not required.

Pharmacy Information

Pharmacy Name: _____ Phone Number: _____

Location / Address: _____

Insurance Information

Primary Insurance: _____ Policy #: _____

Group #: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship: _____

Secondary Insurance: _____ Policy #: _____

Group #: _____ Subscriber Name: _____

Subscriber Date of Birth: _____ Relationship: _____

Responsible Party (Guarantor) Information

Guarantor Name (if different from patient): _____

Guarantor Date of Birth: _____ Phone: _____

Address (if different from patient): _____

Guardianship / Medical Power of Attorney
Do you have a legal representative, or does someone make medical decisions for you? ☐ Yes ☐ No
If you answered "Yes", please provide a copy of legal guardianship / power of attorney paperwork.

Name: _____ Phone: _____

Hospice Care
Are you currently under inpatient or outpatient hospice care? ☐ Yes ☐ No

Hospice Care Service: _____ Phone: _____