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: ______________________________