

# Patient Registration and History

**Patient:** \_\_\_\_\_  
Last Name First Name Middle

**Preferred Contact #:** (please indicate home, work or cell) \_\_\_\_\_

**Phone #2:** \_\_\_\_\_ **Phone #3:** \_\_\_\_\_

**Email address:** \_\_\_\_\_

**Local Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Billing/Permanent Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Emergency contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Social Security #:** \_\_\_\_\_ **Sex:** Male Female **Birthdate:** \_\_\_\_\_ **Age:** \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Referred by:** \_\_\_\_\_

**Eye Doctor:** \_\_\_\_\_ **Primary Physician:** \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

**Allergies** to medicine: No \_\_\_\_\_ Yes \_\_\_\_\_ Please list: \_\_\_\_\_

**Current Medications/Vitamins:** \_\_\_\_\_

Are you a smoker? (circle) Yes / No Ex-Smoker? Yes / No

How much are (were) you smoking? \_\_\_\_\_ How long? \_\_\_\_\_ Quit how long ago? \_\_\_\_\_

How much alcohol do you drink? (circle) <1 drink/day 1 - 2 drinks/day >2 drinks/day

Please circle all of the following medical conditions you now have or have had in the past: high blood pressure / bleeding tendency / problems scarring or delayed healing / cancer / hepatitis / HIV / diabetes / blood transfusions / glaucoma / dry eyes / lung disease / asthma or wheezing / emphysema / bronchitis / irregular heart beat / chest pain / heart disease / heart attack / stroke / epilepsy / heart burn / intestinal ulcers or bleeding / thyroid disease / depression / mental illness / drug or alcohol addiction / other \_\_\_\_\_

Is there any possibility that you might be pregnant at this time? Yes / No

List all surgeries that you have had (include plastic surgery) \_\_\_\_\_

I agree that the above information is accurate to the best of my ability.

Signature: \_\_\_\_\_

Patient #: \_\_\_\_\_

Date: \_\_\_\_\_



CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations- and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

PATIENT: I understand the office's notice of Privacy Practices.

Signature of Patient or Legal Representative \_\_\_\_\_

Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_



## INSURANCE INFORMATION

Please fill out the following and provide a current copy of your insurance card(s).

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security: \_\_\_\_\_

Date: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Name of Insured or write Self: \_\_\_\_\_

Relationship: \_\_\_\_\_

Their Date of Birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Name of Insured or write Self: \_\_\_\_\_

Relationship: \_\_\_\_\_

Their Date of Birth: \_\_\_\_\_

IN ORDER TO SUBMIT YOUR VISIT(S) TO INSURANCE, PLEASE SIGN BELOW:

All questions regarding insurance of fees should be asked prior to services being rendered. Payment is due at the time of your visit unless prior arrangements have been discussed. I hereby authorize the release of any medical information necessary to process my insurance. I hereby authorize payment of medical and/or surgical benefits to Andrea N Hass, MD or Brian E. Hass, MD for any services furnished to me by this physician when insurance is applicable. I understand that I am financially responsible for the charges regardless of my coverage. I further agree that in the event such account must be referred to a collection agency or an attorney for court collections, I will be held responsible for any and all cost resulting from such action. A photocopy of this authorization or faxed copy shall be considered as effective and as valid as the original.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**MEDICAL AUTHORIZATION FOR  
PATIENT INFORMATION**

I, \_\_\_\_\_ **HEREBY AUTHORIZE ANY HOSPITAL, PHYSICIAN, MEDICAL PRACTITIONER, CLINIC, OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY, PHARMACY, INSURANCE COMPANY OR GOVERNMENT AGENCY TO DISCLOSE OR FURNISH TO DR. HASS, OR THEIR REPRESENTATIVES, ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS, INJURY, MEDICAL HISTORY, DENTAL HISTORY, CONSULTATIONS, PRESCRIPTIONS, TREATMENT OR BENEFITS AND COPIES OF ALL APPLICABLE RECORDS THAT MAY BE REQUESTED.**

I ALSO REQUEST THAT \_\_\_\_\_,

RELATIONSHIP, \_\_\_\_\_, **BE ALLOWED MEDICAL INFORMATION ABOUT MY CONDITION.**

**A PHOTOSTATIC COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.**

**PATIENT'S NAME:** \_\_\_\_\_

**PATIENT'S DATE OF BIRTH:** \_\_\_\_\_

**SOCIAL SECURITY NUMBER OF PATIENT:** \_\_\_\_\_

**SIGNED:** \_\_\_\_\_  
**PATIENT'S SIGNATURE**

**DATE:** \_\_\_\_\_



## Advertising Tracking Sheet

Thanks for this opportunity to meet you. We would appreciate it if you would tell us how you first learned about us. Was it -

### ADVERTISING

#### Newspapers

- Palm Beach Post
- Palm Beach Daily News - *shiny sheet*
- Your neighborhood paper \_\_\_\_\_
- Other \_\_\_\_\_

#### Magazines

- Palm Beach Illustrated
- Boca Magazine
- Palm Beach Life
- Other \_\_\_\_\_

#### Other Media

- Television (please explain \_\_\_\_\_)
- Radio
- Internet (ASPS site\_\_\_ other\_\_\_)
- Hass Website
- Yellow Pages (which book \_\_\_\_\_)
- Signage on our Building
- Direct Mail Piece

#### OR Word of Mouth

- Friends
- a previous Hass patient \_\_\_\_\_
- Doctor \_\_\_\_\_

If you have seen our ads or any editorial about our office, what specifically did you like or dislike?

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