Patient Registration

SAN JOSE EYE INSTITUTE

Joseph Decker, M.D., F.A.C.S.
George Yang, M.D.

Patient Name: ______________________ SSN: ______________

Address: ______________________________________

City: ______________________ State: __________ Zip: __________

Home Ph: ( ) ______________ Work Ph: ( ) ______________ Cell Ph: ( ) ______________

Preferred Ph: ☐ Home ☐ Work ☐ Cell Email: ______________________

Marital Status: ☐ S ☐ M ☐ W ☐ D ☐ Sep Sex: ☐ M ☐ F Birthdate: __________

Family Doctor: ______________________ Phone: ( ) ______________
First Last

Referring Doctor: ______________________ Phone: ( ) ______________
First Last

Employer: ______________________ Occupation: ______________________

Spouse: ______________________ Daytime Phone: ( ) ______________

Emergency Contact: ______________ Relationship: __________ Phone: ( ) ______________

Primary Insurance Coverage: ______________________________

Subscriber Name: ______________________ ID #: ______________________

Secondary Insurance Coverage: ______________________________

Subscriber Name: ______________________ ID #: ______________________

Consent for Use and/or Disclosure of Information: I hereby give consent to San Jose Eye Institute to use and disclose my protected health information for the purposes of treatment, payment and health care operations.

Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent.

We reserve the right to change the terms of our Notice of Privacy Practices. You may obtain a copy of the current notice by requesting it at the time of your appointment or submitting a written request.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request, but if we do, the restriction will be binding on us.

You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to 123 Di Salvo Ave., Suite #20, San Jose, CA 95128. You may deliver your revocation by any means you choose, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this consent.

Sign: ______________________________ Date: ______________

Print name of patient: ______________________________

If you are signing as the patient's representative,

Print your name: ______________________ Describe your authority: ______________________

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