Patient Registration

SAN JOSE EYE INSTITUTE

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

Name: ______________________ Birthdate: __________ 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

Family Doctor: ______________________ Phone: ( ) __________
First Last

Referring Doctor: ______________________ Phone: ( ) __________
First Last

Employer: ______________________ Occupation: ______________________

Spouse: ______________________ Daytime Phone: ( ) __________

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

Primary Insurance: ______________________ Secondary Insurance: ______________________

Subscriber Name: ______________________ Subscriber Name: ______________________

A message with details of my health information may be left on my preferred phone number: ☐ Y ☐ N

I give my permission to receive appointment reminders and other personal healthy information by text message (message and data rates may apply): ☐ Y ☐ N

Details of my health information may be shared with: ☐ Spouse ☐ Parent ☐ Other: __________

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. I also give permission to contact my pharmacy for confirmation of my medications.

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: __________