Retina Institute
On call for you

REGISTRATION FORM

Patient Name: _____ DOB: _____/_____/_____

Address: _____

City / State / Zip: _____ SSN: _____-_____-_____

Home Phone: (_____)_____-_____Cell: (____)_____-_____Work Phone: (____)_____-_____

Sex: [ ] M [ ] F Marital Status: _____E-Mail address:_____

Name of Emergency Contact:_____ Phone:(_____)_____-_____ Relation:_____

Primary Care Physician / Phone: _____ / (____)_____-_____

Referring Physician / Phone: _____ / (____)_____-_____

Skilled Nursing Facility: [ ] Yes [ ] No Hospice: [ ] Yes [ ] No

Facility Name & Address:_____

INSURANCE INFORMATION:

Primary Insurance: [ ] Yes [ ] No

Name: _____ Address: _____

Policy #: _____ Group #: _____ Phone #: (_____)_____-_____

Main Subscriber: _____ SSN: _____-_____-_____ DOB: _____/_____/_____

Secondary Insurance: [ ] Yes [ ] No

Name: _____Address: _____

Policy #: _____Group #: _____Phone #: (_____)_____-_____

Main Subscriber: _____ SSN: _____-_____-_____ DOB: _____/_____/_____

FINANCIALLY RESPONSIBLE PARTY (if different from above):

Name: _____Address: _____

Relationship: _____ SNN: _____-_____-_____ DOB: _____/_____/_____

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payments for services rendered are due on the same day of service. As part of our services we will submit your insurance claims. Insurance/Financial arrangements should be made with our Patient Relations Dept. prior to injections, lasers, or surgeries.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARTATION:
I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from MEDICARE and/or other insurance provider(s) for services rendered. I understand and agree to the above conditions.

HIPAA PRIVACY RIGHTS AND AUTHORIZATION FOR DISCLOSURE OR PROTECTED HEALTH INFORMATION:
I have read the HIPAA rights and authorization statements and give my consent for disclosure of my medical records related to treatment.

DATE: _____/_____/_____ **SIGNATURE: _____**