

PATIENT REGISTRATION

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security No.: _____ Sex: Male Female

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Emergency Contact: _____ Relation: _____

Home Phone: _____ Work Phone: _____

Referring Doctor: *(first & last name)* _____

Phone# _____ Address: _____

Primary Doctor: *(first & last name)* _____

Phone# _____ Address: _____

INSURANCE

Primary: _____

Policy Holder: _____ DOB: _____

Relationship: _____ ID/Group #: _____

Secondary: _____

Policy Holder: _____ DOB: _____

Relationship: _____ ID/Group #: _____

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I have received a copy of the No Show Policy and agree to its provisions. Patient Initials _____

I request that payment of medical insurance benefits be made directly to Retina Associates for services furnished to me by them. I authorize release of medical information about me to determine these benefits. It is understood that I am responsible for obtaining authorization and referrals for services per the terms of my insurance company contract. Failure to cooperate with Retina Associates in this will result in my ultimate liability for payment of my bill.

Signature

Date