

PATIENT INFORMATION				
Last Name:		First Name:		M.I.:
Mailing Address:			Apt #:	
City:		State:		Zip:
Home Phone:		Cell Phone:		Work Phone:
Email Address:			Appointment Reminders: <input type="checkbox"/> Text Msg <input type="checkbox"/> Email <input type="checkbox"/> Phone Call	
Date of Birth:		Social Security #:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed				
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline		Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> Decline		
Employer:			Phone Number:	

RESIDENTIAL LIVING FACILITY – We will forward your office visit notes to the nurse at your facility	
Do you live at a residential facility, such as a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If so, which facility and unit/floor do you live at?	
Facility/Unit Phone Number:	Facility/Unit Fax Number:

RESPONSIBLE PARTY – If patient is a minor, please fill out parent/guardian information below. <input type="checkbox"/> Same as Patient		
Name:	Date of Birth:	Relationship to Patient:
Mailing Address:		Phone:

EMERGENCY AND HIPAA CONTACT INFORMATION		
Name:	<input type="checkbox"/> Can discuss medical & financial information	
Home Phone:	Cell Phone:	Relationship to Patient:
Name:	<input type="checkbox"/> Can discuss medical & financial information	
Home Phone:	Cell Phone:	Relationship to Patient:
Name:	<input type="checkbox"/> Can discuss medical & financial information	
Home Phone:	Cell Phone:	Relationship to Patient:
Name:	<input type="checkbox"/> Can discuss medical & financial information	
Home Phone:	Cell Phone:	Relationship to Patient:

REFERRING AND PRIMARY CARE PHYSICIANS

Which eye doctor referred you to see us?

Doctor:

Clinic:

Who is your regular eye doctor?

Doctor:

Clinic:

Who is your primary medical doctor?

Doctor:

Clinic:

Have you seen any other doctors for retinal care in the past?

Doctor:

Clinic:

Are there any other doctors participating in your care that we should share correspondence with?

Doctor:

Clinic:

Doctor:

Clinic:

PRIMARY MEDICAL INSURANCE INFORMATION

Insurance Company:

Policy Number:

Are you the policy holder: Yes No

If not, Policy Holder Name:

Policy Holder Date of Birth:

Relationship to Patient:

SECONDARY MEDICAL INSURANCE INFORMATION

Insurance Company:

Policy Number:

Are you the policy holder: Yes No

If not, Policy Holder Name:

Policy Holder Date of Birth:

Relationship to Patient:

I understand that the Centers for Medicare and Medicaid Services and some other third-party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Retina Consultants, Ltd to release all medical information necessary to secure payment of benefits for the third-party payers specified above, and I authorize the use of this signature on all related submissions. I understand that this information may include medical information related to drug and alcohol abuse, sexually transmitted diseases, HIV/AIDS and mental health. I understand that all co-pays are due at the time of service and that I am financially responsible for all charges whether or not they are paid by my insurance. I understand that excessively overdue accounts will be forwarded to an outside collection agency. I acknowledge that I have been provided a copy of the Retina Consultants HIPAA Notice of Privacy Practices document. I understand that this authorization shall remain valid without expiration unless expressly revoked by me in writing. If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf.

Signature of Patient**or Responsible Party:** _____ **Date:** _____