PATIENT INFORMATION

Date: _____

Patient Name: _____ Person Responsible for Bill and Relationship to Patient:

Apt / Ste # _____ _____ _____

Address: _____

Zip: _____ City: _____ State: _____

Sex: (please circle) F M Title: (please circle) Mr. Mrs. Ms. Other _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May leave message: ☐ Home ☐ Work ☐ Cell

Email: _____ Preferred Phone: (Check one) ☐ Home ☐ Work ☐ Cell

Marital Status (please check) Single _____ Married _____ Divorced _____ Widowed _____

Date of Birth: _____ Age: _____ Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Referring Doctor Name: _____

Family Doctor Name, Address, Phone: _____

Ethnicity: _____

Employer _____ Preferred Language: _____ Race: _____

Spouse's Name: _____ Spouse's SS # _____ Spouse's Date of Birth: _____

Person Responsible For Bill: (If self, skip to employer) _____

Apt / Ste # _____

Address: _____

Zip: _____ City: _____ State: _____

Sex: (please circle) F M Title: (please circle) Mr. Mrs. Ms. Other _____

Date of Birth: _____ Age: _____ Social Security # ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May leave message: ☐ Home ☐ Work ☐ Cell

Email: _____ Preferred Phone: (Check one) ☐ Home ☐ Work ☐ Cell

Employer: _____ _____

Circle One: Full Time Part Time Unemployed Self Employed Retired Active Military Reserves

I authorize Retina Associates, P.C. to dilate both of my eyes unless I specifically request this not be done. I am aware that dilation may temporarily impair my ability to drive, operate machinery, read, or walk. Dilation usually lasts about four hours.

I hereby authorize medical imaging and the exchange of information from my medical records with other physicians, optometrists and health care personnel, by voice, mail or facsimile for purposes relating to my care.

I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to Retina Associates, P.C., for services rendered. I further authorize the release of any information needed for processing insurance claims.

I understand that my deductible and co-pay is due at time of service and that I am financially responsible for charges not paid by my insurance company.

Information used and disclosed to be in strict accord with Retina Associates', P.C. HIPAA Privacy Notice. I acknowledge receipt of Retina Associates', P.C. HIPAA Privacy Notice.

Patient Release of Information

Please list names of family members, caregivers or friends to whom we may release your medical information, such as test results, examination findings, appointments, billing information or prescriptions.

NAME	**RELATIONSHIP**	**PHONE**
1._____	_____	HOME:_____ CELL: _____
2. _____	_____	HOME:_____ CELL: _____
3._____	_____	HOME:_____ CELL: _____

_____	_____	_____
Patient's Name	Patient's Signature	Date

(SIGNATURE REFERS TO BOTH SIDES OF PAGE)

COPIES OF THIS FORM ARE AVAILABLE TO THE PATIENT UPON REQUEST