Retina Macula Specialists P. C.

Patient/Insurance Registration Form

(Please Print)

Today Date: _____ **___New Patient ___ Established Patient ___Updated Information**

Name of Referring Physician: _____ **Phone**: _____

Name of Primary Care Physician: _____ **Phone**: _____

Patient Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ Sex: M or F Social Security #_____

Marital Status: (Circle One) **Single** **Married** **Divorced** **Legally** **Separated** **Widowed**

Employer Name: _____ Phone: _____ Occupation: _____

Chose Clinic because /Referred to Clinic by (please circle):
Family/Friend **Close to home/work** **Yellow Pages** **Insurance Plan** **Hospital Other**

Other family members seen at our office: _____

INSURANCE INFORMATION
(A copy of your CURRENT Insurance Card and Identification is Required to keep on file for Billing purposes).

Person Responsible for Bill: _____ Phone: _____

Name of Primary Insurance Holder: _____ Date of Birth: _____

Name of **Primary** Insurance: _____ HMO PPO MEDICAID COMMERCIAL MEDICARE

Name of **Secondary** Insurance: _____ HMO PPO MEDICAID COMMERCIAL MEDICARE

Does the name on the Driver's License or Identification card match Insurance Card? Yes or No

IN CASE of EMERGENCY

Name: _____ Relationship: _____ Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Retina Macula Specialist P.C. or insurance company to release any medical information required to process my claims.

Patient/Guardian/POA Signature: _____ Date: _____