Patient Registration

❒ Form ❒ Insurance Card ❒ New ❒ Update ❒ New Lenox

Acct: ____________________ ❒ Oak Lawn ❒ Orland Park ❒ Joliet ❒ Palos Heights

PLEASE PRINT CLEARLY

Date ____________________ Doctor: ❒ Lipman ❒ Pelzek ❒ Vyas ❒ Amin ❒ Eadie

Patient Name ____________________ Age ________ ❒ Male ❒ Female

Address ____________________ City, State, Zip ____________________

Home Phone ____________________ Alternate # or Cell # ____________________

Date of Birth ______/______/______/ Employer ____________________

Marital Status: PLEASE CHECK ONE ❒ Single ❒ Married ❒ Divorced ❒ Separated ❒ Widowed

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Patient Referred By ____________________ Address/City/Phone ____________________

Family Physician ____________________ Address/City/Phone ____________________

PRIMARY INSURANCE COMPANY ____________________

Policyholder's Name ____________________ Policy # ____________________

Relationship to patient ____________________ Date of Birth ____________________

SECONDARY INSURANCE COMPANY ____________________

Policyholder's Name ____________________ Policy # ____________________

Relationship to patient ____________________ Date of Birth ____________________

NURSING HOME RESIDENT? ❒ **YES** ❒ **NO** **STATUS?** ❒ **IN-PATIENT** ❒ **OUT-PATIENT**

Facility Name ____________________ City ____________________

If Patient is a minor, who is responsible? ____________________

Relationship to patient ____________________ Phone # ____________________

If accident, were you injured at: ❒ Work ❒ Auto ❒ Other ____________________

What happened? ____________________ Date of Accident ____________________

Person to contact ____________________ Phone # ____________________

Comprehensive diagnostic and surgical care of the retina, macula and vitreous

Financial Responsibility Statement/Release of Information Authorization

Medicare

I request that payment of authorization Medicare benefits be made to Retina Vitreous Associates on my behalf for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Medicare Supplement

I request that payment of authorization Medigap benefits be made on my behalf to Retina Vitreous Associates for any services furnished me by their physicians. I authorize any holder of medical information about me to release to my insurance any medical information needed to determine these benefits or the benefits payable for related services.

Private Insurance

I authorize Retina Vitreous Associates to furnish information to insurance carriers concerning the illness or medical treatment of my dependent or myself, and I hereby assign to the provider(s) all insurance payment for medical services rendered to myself or my dependent. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have to assist me in this responsibility. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

HMO/PPO/POS

I understand that I am responsible for obtaining a referral, referral number, authorization number and/or precertification number for all visits/services performed by Retina Vitreous Associates and its physicians. If my HMO/PPO managed care plan denies payment due to lack of required referrals, referral numbers, authorization numbers, and/or precertification numbers, I agree to be personally and fully responsible for payment.

Signature of Patient or Responsible Party:________________________________

Date: ____