Patient Registration

Acct: ______________________ ❒ New ❒ Update ❒ Merrillville ❒ Michigan City ❒ Munster ❒ Valparaiso

PLEASE PRINT CLEARLY

Date ______________________ Doctor: ❒ Amin ❒ Chasan ❒ Eadie ❒ Lipman ❒ Pelzek ❒ Vyas

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

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 Associates on my behalf for any services furnished me by their physician. I authorize and 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 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 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 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: ______________________________