



Patient Registration

- New Update
 Munster Merrillville Michigan City

Acct: _____

PLEASE PRINT CLEARLY

Date _____ Doctor: Amin 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: _____