

PLEASE COMPLETE BOTH FORMS AND BRING THEM WITH YOU.

PATIENT REGISTRATION

Please print clearly

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____

DATE OF BIRTH: _____ AGE: _____ MALE FEMALE

SOCIAL SECURITY NUMBER: _____

WORK STATUS: PART-TIME FULL-TIME RETIRED FULL-TIME STUDENT

EMPLOYER: _____ OCCUPATION: _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED

SPOUSE'S NAME: _____ DAY PHONE: _____

REFERRAL INFORMATION

REFERRING PHYSICIAN: _____

Specialty: (circle one) Ophthalmologist Optometrist Internist Family Practitioner

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE: (____) _____

PRIMARY CARE PHYSICIAN: _____ PHONE: (____) _____

INSURANCE INFORMATION *Please present your insurance card to the receptionist*

Primary Insurance Company: _____

Insured's Name: _____ Relationship to Patient: _____

Group Number: _____ Social Security #: _____

Secondary Insurance Company: _____

Insured's Name: _____ Relationship to Patient: _____

Group Number: _____ Social Security #: _____

2 SIDES PLEASE

EMERGENCY CONTACT: _____

RELATIONSHIP TO PATIENT: _____ DAY PHONE: _____

IF YOUR ILLNESS OR INJURY IS WORK RELATED, please provide:

DATE OF INJURY: _____

WORK COMP INFO: _____ PHONE: _____

BENEFITS AND MEDICAL RELEASE AUTHORIZATION

Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, co-payment or any balance not paid for by your insurance.

I hereby authorize payment of Medicare or other insurance benefits available for medical or surgical services to California Retina Consultants.

I authorize the release of any medical information requested by my insurance company concerning my illness, surgery or injury.

I understand that if I am a member of a Health Maintenance Organization (HMO), I am responsible for obtaining prior authorization from my Primary Care Physician for all visits and procedures performed in this office. I understand that if prior authorization is not obtained, I may be responsible for the charges incurred on that particular date of treatment. I understand that all co-payments are due at the time of the visit or procedure.

PATIENT NAME: _____
(please print)

SIGNED: _____ DATE: _____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have been offered a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be located in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

The Notice of Privacy Practices will be offered to me at my first office visit.

Signed Date

Print Name: _____