Premier Retina Specialists
REGISTRATION FORM

PLEASE FILL OUT EVERY BOX!! Then print the form and bring it with you.

Race: White ❑ (NOT Hispanic ❑ OR Hispanic ❑) African American ❑ Asian ❑ American Indian ❑ Native Hawaiian or South Pacific Island ❑	**Referring Dr:**

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) ❑ Single ❑ Married ❑ Divorced ❑ Widowed	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date:	Age: Sex: ❑ M ❑ F
Street address:	Social Security #:	Preferred Contact Number: Home Cell Work ( )		
P.O. box:	City:	State:	ZIP Code:	
Occupation:	Employer:	Employer phone : ( )		
EMAIL ADDRESS:	**Medical Dr:**	Alt Phone:	( )	
Preferred language: ❑ ENGLISH ❑ SPANISH ❑ Other				
Pharmacy:	**City:**	**Street:**		

INSURANCE INFORMATION

(Please give your insurance card to the receptionist AFTER filling in the information.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )		
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Name of primary insurance:	Billing Address: Street/PO Box	City:	State	Zip	
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-pay/Ded: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home/cell phone : ( )	Work/cell 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 **Premier Retina Specialists** or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

This office follows the guidelines of MEDICAL MEANINGFUL USE as designed by the U.S. Government and every element of this form is necessary for our records.

V 1.15