

**PATIENT INFORMATION**

(Please Print)

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Zip: \_\_\_\_\_ SEX: \_\_\_\_\_

Birthdate: \_\_\_\_\_ AGE: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Social Security # \_\_\_\_\_ Occupation: \_\_\_\_\_

**Employer (Past or Present):** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Primary Physician (PCP): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**PERSON TO NOTIFY FOLLOWING SURGERY OR IN AN EMERGENCY**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

SIGNATURE KEPT AS A RECORD OF CONSENT GIVEN TO PROCESS COMPUTERIZED INSURANCE FORMS AND AUTHORIZE PAYMENT OF BENEFITS DIRECTLY TO RETINA VITREOUS CENTER, PA. IF PATIENT IS A MINOR, PARENT OR LEGAL GUARDAIN MUST SIGN BELOW AS A RELEASE FOR EXAM AND/OR TREATMENT. A SERVICE CHARGE OF 1.5% PR MONTH (18% ANNUALLY) WILL BE CHARGED ON PATIENT BALANCES OVER 60 DAYS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS OR MY INSURANCE CARRIER ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELEASED SERVICES.

Patient Signature: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

**GUARANTOR (POLICYHOLDER) INFORMATION**

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ SS #: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Employer (Past or Present):** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_

**PRIMARY INSURANCE**

Insurance Carrier: \_\_\_\_\_ ID # \_\_\_\_\_

Policy / ID Number: \_\_\_\_\_ Group # \_\_\_\_\_ Coverage Code: \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Carrier: \_\_\_\_\_ ID# \_\_\_\_\_

Policy / ID Number: \_\_\_\_\_ Group # \_\_\_\_\_ Coverage Code: \_\_\_\_\_

**Employer (Past or Present):** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_