Retinal Consultants
Patient Registration

Please read carefully before completing form.

We expect an insurance form completed if indicated for your insurance coverage.
We will also need copies of all insurance cards (including Medicare cards).

Patient Name: _____ Age: _____
(Last) (First) (Middle)

Date of Birth: ___/___/____ Gender: ☐ Male ☐ Female Home Phone: (____) _____
mm / dd / yyyy

Address: _____ Cell Phone: (____) _____

City: _____ State: _____ Zip: _____

Patient's Social Security Number: _____-_____-_____ Language Preferred: _____

Employer: _____

Primary Insurance: _____ Medical Group: _____

Secondary Insurance: _____ Medical Group: _____

Third Insurance: _____ Medical Group:_____

Spouse's Name/Guarantor: _____ Guarantor's Date of Birth: _____/_____/_____

Guarantor/Spouse's Social Security Number: _____-_____-_____

Are you living in a skilled nursing facility? ☐ Yes ☐ No

Referring Physician: _____

Primary Medical Doctor: _____

In Case of Emergency— Please list nearest relative/friend we may contact (not living with you).

Name: _____ Telephone: (_____) _____

Insurance Authorization and Assignment

I hereby authorize the Retinal Consultants Medical Group, Inc. to furnish information to insurance carriers, and any other physicians involved in my care, related to my illness and treatments. I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts due as a result of providing false or incorrect insurance information and for any non-covered services (as defined by my health plan).

Date: _____ Signature: _____

Revised 10-07-13