

# 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: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
Month Day Year

Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

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: \_\_\_\_-\_\_\_\_-\_\_\_\_

Referring Physician: \_\_\_\_\_

Primary Medical Doctor: \_\_\_\_\_

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

Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

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### 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, regarding my illness and treatments. I hereby assign to the physician(s) all payment for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by the insurance company.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_