

PATIENT REGISTRATION

PATIENT #: _____

NAME: _____ EXAM DATE: _____
 STREET ADDRESS: _____ CITY: _____ STATE: _____
 ZIP CODE: _____ HOME PHONE: _____ WORK PHONE: _____
 ALTERNATE PHONE: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F
 PATIENT'S SOCIAL SECURITY #: _____
 MARITAL STATUS: _____ RACE: _____
 PATIENT'S EMPLOYER: _____ PATIENT'S OCCUPATION: _____
 ADDRESS: _____ PHONE #: _____
 EMPLOYMENT STATUS: ACTIVE RETIRED DISABLED RETIRED/DISABILITY DATE: _____
 SPOUSE'S NAME (OR PARENT'S IF PATIENT IS A MINOR): _____
 SPOUSE'S EMPLOYER: _____ PHONE #: _____
 EMPLOYER ADDRESS: _____
 PERSON TO CONTACT IN AN EMERGENCY: _____
 RELATIONSHIP TO PATIENT: _____ PHONE #: _____
 REFERRED BY: _____ PHONE #: _____
 FAMILY PHYSICIAN/INTERNIST: _____ PHONE: _____

ARE YOU ALLERGIC TO ANY MEDICATION? YES NO

IF YES, PLEASE LIST: _____

PRIMARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ POLICY #: _____
 INSURED SOCIAL SECURITY #: _____ GROUP #: _____
 RELATIONSHIP TO PATIENT: _____ BIRTHDATE: _____
 EMPLOYER: _____ WORK PHONE #: _____

SECONDARY INSURANCE COMPANY NAME: _____

INSURED NAME: _____ POLICY #: _____
 INSURED SOCIAL SECURITY #: _____ GROUP #: _____
 RELATIONSHIP TO PATIENT: _____ BIRTHDATE: _____
 EMPLOYER: _____ WORK PHONE #: _____

I AUTHORIZE CAROLINA RETINA CENTER TO RELEASE ANY MEDICAL INFORMATION NEEDED TO DETERMINE BENEFITS FOR RELATED SERVICES TO MY INSURANCE COMPANY, WORKMAN'S COMPENSATION CARRIER, OR ANY OTHER REIMBURSEMENT AGENT.

I HEREBY ASSIGN ALL MEDICAL AND/OR SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED INCLUDING MEDICARE, PRIVATE INSURANCE AND OTHER HEALTH PLANS TO CAROLINA RETINA CENTER. THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS AN ORIGINAL.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE, FURTHERMORE I AGREE TO PAY ALL REASONABLE INTEREST FEES, ATTORNEY FEES AND COLLECTIONS COSTS SHOULD SUCH BE NECESSARY TO COLLECT PAYMENT ON THIS ACCOUNT. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION TO SECURE THE PAYMENT.

SIGNED/RESPONSIBLE PARTY: _____ **DATE:** _____