Iowa Retina Consultants, Inc.
PATIENT REGISTRATION

Patient's Legal Name ________________________________ Date __________
Street Address __________________________________ Apt/Unit/Lot ________
City __________________________ State ______________ Zip ____________
Home Phone (____)______-_______ Cell Phone (____)______-_________
May we leave a message on your home answering machine? Y ______ N _______
Social Security #________________ Birthdate __________________ Age______
Female_____ Male_____ / Single___ Married____ Divorced____ Widowed_____
Email address: ____

Patient Occupation _______________ Employed by ______________________
Is appt work related? Y_____ N______ Contact ______________________
Work Phone (____)_____-______ May we call you at work? Y_____ N _____

Spouse's Name: _____________________ Cell Phone (____) _____-_______
Birthdate: __________________________ SS# ________________________
Employer ___________________________ Work # (____) _____-__________

Contact Person Other than Spouse (Family / Friend)
Name _______________________ Relationship ______________________
Home phone (____)_____-______ Cell phone (_____) _______-________

Ins. Policy holder (if other than patient):________________________________
Address: _________________________________ Phone (_____) _____-______
Relationship: ________________ DOB: ______________ SS#_____________
Employer:_____________________________ Work phone:_________________

Are you currently in hospice care? Y___ N ____ / Nursing facility? Y____ N_____
Name of facility: _______________________ Phone (____) _______-__________
Level of care: Residential ________ Intermediate ________ Skilled __________

If you have Medicare, is it primary___ secondary ___ / Disabled? Y____ N ____
Is spouse working? Y_____ N_____ / End stage renal failure?: Y_____ N _____

____
Reviewed by patient and confirmed all information is current: (Initial and date)

_______________ _____________ _____________ ______________

OVER

Primary Medical Doctor ____
(First Name) (Last Name)
Primary Medical Doctor Phone (_____) ______ – _____________
Primary Eye Care Doctor ____
(First Name) (Last Name)
Referring Doctor ____
(First Name) (Last Name)

RELEASE OF INFORMATION AUTHORIZATION

Name ___________________________Relationship___________Phone________
Name ___________________________Relationship___________Phone________
Name___________________________ Relationship___________Phone________

PAYMENT POLICY

I authorize Iowa Retina Consultants, Inc. to release all information to secure payment. I assign all medical benefits to which I am entitled to Iowa Retina Consultants, Inc. for services rendered by same. 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.

Patients who do not have health insurance coverage will be expected to pay **at the time of service** unless other arrangements have been made with Iowa Retina Consultants, Inc. You are responsible for the payment of your account regardless of insurance coverage.

Most insurance companies require us to collect office co-payments at the time of service. It is not our policy to bill for co-pays. Co-pays are due at the time of service.

By providing us with your wireless/cell phone number, you are hereby granting us, and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes.

I understand and agree to the payment policy as stated above. I acknowledge I understand the Notice of Privacy Practices implemented by Iowa Retina Consultants, Inc.

Signature _______________________________________ Date______________