Iowa Retina Consultants, Inc.
PEDIATRIC PATIENT REGISTRATION

Patient's Legal Name _____Date_____

Address_____Apt/Unit/Lot #_____

City _____ State _____Zip_____

Home Phone (_____) _____- _____ Sex: Female / Male (circle one)

May we leave a message on your home answering machine? Yes / No (circle one)

Social Security No. _____ Date of Birth _____ Age _____

Student: Yes / Full Time / Part Time / No (circle one)

Mother's Name _____
Date of Birth _____ Social Security #_____
Address_____ City_____ State _____ Zip_____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____
Marital Status: Married / Single / Widowed / Divorced (circle one)
Employer _____ Work Phone (_____) _____-_____
Spouse's Name_____ Relationship to Patient _____

Father's Name _____
Date of Birth _____ Social Security #_____
Address_____ City _____ State_____ Zip_____
Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____
Marital Status: Married / Single / Widowed / Divorced (circle one)
Employer _____ Work Phone (_____) _____-_____
Spouse's Name _____ Relationship to Patient _____

Person Holding Insurance:
Name _____
Address _____
Phone (_____) _____ - _____

Primary Medical Doctor _____
(First Name) (Last Name)
Primary Medical Doctor Phone (_____) _____-_____
Primary Eye Care Doctor (Not IRC)_____
(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 that I am aware of the Notice of Privacy Practices implemented by Iowa Retina Consultants, Inc.

Parent or Guardian
Signature _____ Date _____