iowaretina.com

IOWA RETINA CONSULTANTS

PATIENT REGISTRATION

Patient's Name _____ Date _____
(Last) (First) (MI)

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 ☐ Widow ☐ Widower

Email address: _____

Primary Language: _____ Interpretor needed? ☐ Y ☐ N

Employer: _____ Is appt work related? ☐ Y ☐ N

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) / Responsible party: _____

Address: _____ Phone: (_____) _____ - _____

Relationship: _____ DOB: _____ SS #: _____

Employer: _____ Work #: (_____) _____ - _____

Are you currently in hospice care? ☐ Y ☐ N Nursing facility? ☐ Y ☐ N

Name of facility: _____ Phone: (_____) _____ - _____

Level of care: ☐ Residential ☐ Assisted ☐ ICF ☐ Skilled

If you have Medicare, is it ☐ Primary ☐ Secondary Disabled? ☐ Y ☐ N

Is spouse working? ☐ Y ☐ N End stage renal failure? ☐ Y ☐ N

FOR OFFICE USE ONLY: DO NOT WRITE BELOW THIS LINE

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

_____ _____ _____ _____

PLEASE COMPLETE OTHER SIDE

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 (HIPAA)

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 _____

Statement of nondiscrimination: Iowa Retina Consultants complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you need help or speak a non-English language, call 1-515-222-6400; 1-800-825-8462, to request an interpreter for your appointment.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-515-222-6400; 1-800-825-8462.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-515-222-6400; 1-800-825-8462。