iowaretina.com

IOWA RETINA CONSULTANTS

PEDIATRIC PATIENT REGISTRATION

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

Address _____ Apt/Unit/Lot # _____

City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Sex: ☐ Female ☐ Male

May we leave a message on your home answering machine? ☐ Yes ☐ No

Social Security No. _____ Date of Birth _____ Age _____

Primary language: _____ Interpreter needed ☐ Yes ☐ No

Mother's Name _____

Date of Birth _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Email: _____ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Employer _____ Work Phone (_____) _____ - _____

Spouse's Name _____

Father's Name _____

Date of Birth _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ - _____ Cell Phone (_____) _____ - _____

Email: _____ Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Employer _____ Work Phone (_____) _____ - _____

Spouse's Name _____

Name of Person Holding Insurance: _____ DOB _____

Employer _____

Address _____ City _____ State _____ Zip _____
(IF DIFFERENT THAN ABOVE)

Phone (_____) _____ - _____

PLEASE COMPLETE OTHER SIDE

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 (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 that I am aware of the Notice of Privacy Practices implemented by Iowa Retina Consultants, Inc.

Parent or Guardian
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 speak English, language assistance services, free of charge, are available to you. Call 1-515-222-6400; 1-800-825-8462.

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。