Patient Registration Form

PATIENT NAME: _____ **CHART #:** _____

ADDRESS: _____ **CITY:** _____ **STATE:**___ **ZIP CODE:** _____

HOME PHONE #: _____ **OTHER PHONE #:** _____

SOCIAL SECURITY NUMBER: _____ **DATE OF BIRTH:** _____

EMAIL: _____

MARITAL STATUS: (circle one) SINGLE MARRIED DIVORCED WIDOWED OTHER

SEX:(circle one) FEMALE MALE

PRIMARY CARE PHYSICIAN: _____ **REFERRED BY:** _____

DO YOU REQUIRE A LANGUAGE INTERPRETER: (circle one) YES NO **LANGUAGE:** _____

PATIENT'S EMPLOYER INFORMATION: **MAY WE CALL YOU AT WORK?** (circle one) YES NO

COMPANY: _____ **PHONE #:** _____

IS TODAY'S VISIT WORK COMP RELATED: (circle one) YES NO
(If yes, please request additional paperwork from receptionist.)

PATIENT CONTACTS & HIPAA RELEASE

NAME: _____ **RELATIONSHIP:** _____ **PHONE #:** _____
Authorization to Release Info:(circle one) YES NO

NAME: _____ **RELATIONSHIP:** _____ **PHONE #:** _____
Authorization to Release Info:(circle one) YES NO

NAME:_____ **RELATIONSHIP:** _____ **PHONE #:** _____
Authorization to Release Info:(circle one) YES NO

RESPONSIBLE PARTY INFORMATION

RESP. PARTY NAME: _____

ADDRESS: _____ **CITY:** _____ **STATE:** ____ **ZIP CODE:** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY #:** _____ **SEX:** (circle one) FEMALE MALE

HOME PHONE #: _____ **OTHER PHONE #:** _____

PATIENT RELATIONSHIP TO THE RESP. PARTY:(circle one) SELF SPOUSE CHILD OTHER _____

RESPONSIBLE PARTY'S EMPLOYER INFORMATION:

COMPANY: _____ **PHONE #:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

ADDRESS: _____ **PHONE:** _____

CONTRACT (ID#) NUMBER: _____ **SUBSCRIBER'S NAME:**_____

PATIENT RELATIONSHIP TO SUBSCRIBER: (circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ **GROUP NUMBER:** _____

COPAYMENT AMOUNT: $_____ **INSURED'S DATE OF BIRTH:**_____

SECONDARY INSURANCE COMPANY: _____

ADDRESS:_____ **PHONE:**_____

CONTRACT (ID#) NUMBER: _____ **SUBSCRIBER'S NAME:** _____

PATIENT RELATIONSHIP TO SUBSCRIBER:(circle one) SELF SPOUSE CHILD OTHER

GROUP NAME: _____ **GROUP NUMBER**: _____

COPAYMENT AMOUNT: $_____ **INSURED'S DATE OF BIRTH**:_____

OTHER REQUIRED MEDICARE QUESTIONS

Are you currently in a nursing facility? (circle one) YES NO

Name of Facility: _____ **Phone #:** _____

Level of Care: (circle one) RESIDENTIAL ASSISTED ICF SKILLED

Are you currently in hospice care? (circle one) YES NO

If you have Medicare, is it: (circle one) PRIMARY SECONDARY

Are you disabled? (circle one) YES NO

Is your spouse working? (circle one) YES NO

Are you in End Stage Renal Failure? (circle one) YES NO

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 arrrangements have been made with Iowa Retina Consultans, 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.