The Retina Group

New Patient Information

Date: _____

Last Name: _____

First Name: _____

Date of Birth: _____

Social Security #: _____

Ethnicity: _____

Religion: _____

Address: _____

City: _____ State: _____

Zip Code _____ Home Phone: _____

Work Phone: _____

Cell Phone: _____

Race: _____

Preferred Language: _____

Emergency Contact Information

Last Name: _____

First Name: _____

Relationship to Patient: _____

Cell Phone: _____

Address: _____

City: _____ State: _____

Zip Code _____ Home Phone: _____

Work Phone: _____

POA/ Legal Guardian Information (Legal documentation must be provided)

Last Name: _____

First Name: _____

Relationship to Patient: _____

Cell Phone: _____

Address: _____

City: _____ State: _____

Zip Code _____ Home Phone: _____

Work Phone: _____

Physician Information

Primary Physician: _____

Address: _____

City: _____ State: _____

Zip code: _____ Phone: _____

Fax: _____

Referring Physician: _____

Address: _____

City: _____ State: _____

Zip Code: _____ Phone: _____

Fax: _____

INSURANCE COVERAGE INFORMATION

If your insurance coverage changes, it is your responsibility to notify our office. Failure to do so could result in denial of service(s) rendered to you and may leave you financially responsible.

****If you are not the Policy/Member holder and are a dependent on the plan please provide the Members information below.**

Primary Insurance:

1) Insurance Company Name:_____
2) Member ID Number:_____
3) Group Number:_____
4) Members Name:_____
5) Date of birth:_____
6) Social Security Number (if permission is given):_____

Secondary Insurance (if applicable):

1) Insurance Company Name:_____
2) Member ID Number:_____
3) Group Number:_____
4) Members Name:_____
5) Date of birth:_____
6) Social Security Number (if permission is given):_____

Tertiary Insurance (if applicable)

1) Insurance Company Name:_____
2) Member ID Number:_____
3) Group Number:_____
4) Members Name:_____
5) Date of birth:_____
6) Social Security Number (if permission is given):_____

By signing below, I authorize **The Retina Group, Inc.** to release any Medical information necessary for insurance claim submission, and request that Medical Benefit payment be made directly to **The Retina Group, Inc.** for services rendered.

Patient/ Guardian Signature: _____ Date: _____