PATIENT INFORMATION FORM

Retina Specialists
of Alabama LLC

E-Mail _____ Today's Date: _____

Patient's Name: _____
LAST FIRST MID. INIT.

Address: _____ Home Telephone: _____

City, State, & Zip: _____ Cell Phone #: _____

Date of Birth: _____ Sex: _____ Race: _____ Social Security #: _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed Ethnicity: _____

Employer: _____ Work Telephone: _____

Occupation: _____ Retired: ❑ Yes ❑ No Disabled: ❑ Yes ❑ No

If Retired, Name of Company Retired From: _____ Retirement Date: _____

Doctor Who Referred You To Us: _____

If not Physician referred. how did you hear of our practice? ❑ Friend ❑ Internet ❑ Other _____

If Friend, was he/she an RSA patient? ❑ No ❑ Yes Name: _____

Medical Doctor/Diabetic Doctor: _____ Preferred Language: _____

Pharmacy Name: _____ Telephone: _____

Spouse's Name: _____ Date of Birth: _____

Social Security #: _____ Spouse Cell Phone # _____

Employer: _____ Work Telephone: _____

Person To Contact In Case Of Emergency (Not Living With You):

Name: _____ Telephone: _____
Relationship

BILLING INFORMATION

Primary Insurance

Name of Insurance: _____

Contract #: _____ Group Name: _____ Group #: _____

Name Of Policy Holder: _____ Policy Holder's Date Of Birth: _____

Relationship To Policy Holder: _____

Secondary Insurance

Name of Insurance: _____

Contract #: _____ Group Name: _____ Group #: _____

Name Of Policy Holder: _____ Policy Holder's Date Of Birth: _____

Relationship To Policy Holder: _____

Work Comp / Voc Rehab / Other?

Eye Injury? _____ Which Eye? _____ Date of Injury: _____

PLEASE SIGN RELEASE OF INFORMATION AUTHORIZATION ON BACK OF THIS FORM

Registered By: _____ Account #: _____ Date: _____

COMPLETE THIS SECTION IF PATIENT IS A MINOR OR STUDENT

Person Responsible For Bill: _____

Father's Name: _____ Social Security #: _____

Address: _____ Home Telephone: _____

Employer: _____ Date of Birth: _____

Occupation: _____ Work Telephone: _____

Mother's Name: _____ Social Security #: _____

Address: _____ Home Telephone: _____

Employer: _____ Date of Birth: _____

Occupation: _____ Work Telephone: _____

EXPLANATION OF COLLECTION AND CHARGES
(A LIST OF CHARGES WILL BE FURNISHED UPON REQUEST)

PAYMENT POLICY

PAYMENT ARRANGEMENTS MUST BE MADE AT THE TIME SERVICE IS RENDERED. I UNDERSTAND THAT RETINA SPECIALISTS OF ALABAMA, LLC ("THE PRACTICE") MAY ASSIST WITH FILING OF INSURANCE FORMS, BUT I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

AGREEMENT TO PAY

I agree to pay all amounts for services rendered to me by the Practice unless and only to the extent the Practice is otherwise obligated to accept payment from a third party. I agree to pay the attorney fees and collection costs in the event it becomes necessary to retain such services for collection of my account.

AUTHORIZATION TO RELEASE INFORMATION

I authorize the release of medical information and records concerning my treatment to Medicare, Medigap and/or other insurance companies and assign my claim for medical benefits to the Practice to the extent permitted under applicable law or insurance agreements. I agree to allow the Practice to request and release my medical records from the other physicians or medical institutions as it deems necessary for my medical care and I further authorize the release of my medical records by such parties for such purpose. I agree to allow the Practice to use my medical information and photography in an anonymous manner for the purpose of research, tracking or publication. I release the Practice from all legal responsibility or liability that may arise from the above authorization and agreements.

APPOINTMENT REMINDER POLICY

I authorize this Practice and their agent to place appointment reminder phone calls to the phone number I have listed on my patient form.

CONSENT TO TREATMENT

I authorize the physicians of the Practice, their associates, technical assistants and other health care providers under their direction to provide diagnostic evaluation and treatment. I agree to pupillary dilation for the purpose of examination and have been advised not to drive. I understand that no guarantee has or will be made to me regarding any possible result or cure based on my examination and/or treatment.

Patient Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____

Patient Signature: _____ **Date:** _____