PATIENT INFORMATION FORM

Retina Specialists
of West Alabama LLC

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 RSWA patient? ☐ No ☐ Yes Name: ____________________

Medical Doctor/Diabetic Doctor: ____________________ Preferred Language: ____________________

Preferred Pharmacy ____________________ Telephone: ____________________

Pharmacy Address: ____________________

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: ____________________ Relationship Telephone: ____________________

BILLING INFORMATION

Primary Insurance

Name of Insurance: ____________________

Contract #: ____________________ Group Name: ____________________ Group #: __________

Relationship To Policy Holder: ____________________ Policy Holder's Date Of Birth: __________

Name Of Policy Holder: ____________________

Secondary Insurance

Name of Insurance: ____________________

Contract #: ____________________ Group Name: ____________________ Group #: __________

Relationship To Policy Holder: ____________________ Policy Holder's Date Of Birth: __________

Name Of 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 WEST 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 teaching or publication. I release the Practice from all legal responsibility or liability that may arise from the above authorizations 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:** ____________