

BWD LK SW YT AKR WRN MTR LRN SLM
LJS MAN HZ ZNZ SDP DGM JMC

Date ____/____/____

Please print clearly

Patient Information

Marital Status Married Single Widowed Divorced Date of Birth ____/____/____
Name _____ Home phone # _____
Address _____ Cell phone # _____
City _____ State ____ ZIP ____ Soc. Sec. # _____
Sex Male Female Do you live in a nursing facility? No Yes
Date of Admission ____/____/____
Name of facility: _____

Employment Status

Employed Employer _____ Phone # _____
 Retired Retired from (Company name) _____ Unemployed

Person to notify in case of emergency Name _____
(with phone number different from yours) Relationship _____ Phone # _____

Insurance Information

If you have no insurance, our business office will arrange a payment plan.

Please present your insurance cards to be copied.

Primary _____
Secondary _____
Other _____

In whose name is your insurance carried? _____ His/Her Date of Birth ____/____/____
Employer _____ Date of Coverage _____ His/Her Soc. Sec. # _____

Referral Information

Whom may we thank for referring you to our practice?

Referring Doctor / Source _____ MD OD Phone # _____
Address _____ City _____ State ____ ZIP ____

Any other eye doctor _____

Primary care doctor _____ MD DO Phone # _____
Address _____ City _____ State ____ ZIP ____

E-mail Newsletter

Would you like to receive our newsletter by e-mail?
 No Yes E-mail address _____
If you'd like to have our newsletter e-mailed to a relative or friend, please write the address(es) here. E-mail address _____
E-mail address _____

Authorization to Release Information

I hereby authorize Retina Associates of Cleveland, Inc and/or its employees or agents to release any information acquired in the course of my examination or treatment to my insurance company (companies) for claims processing.

Patient's Signature

Date

Medicare Patient Authorization Notice

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize **Retina Associates of Cleveland, Inc.**, as holder of any medical or other information about me, to release to the Social Security Administration or its intermediaries or carriers any information needed for these or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

I request that payment under the Medical Insurance Program be made directly to **Retina Associates of Cleveland, Inc.** on any bills for services furnished me by **Retina Associates of Cleveland, Inc.** during the full period of my treatment by any of the physicians and/or agents of **Retina Associates of Cleveland, Inc.**

Patient's Signature

Medicare # (include letter)

Date

Blue Cross/Blue Shield Authorization to Pay Benefits

I hereby authorize Blue Cross/Blue Shield of Ohio to pay on my behalf such insurance benefits as are covered under my contract for services provided by one or more physicians and/or agents of **Retina Associates of Cleveland, Inc.** and reported to BC/BS.

Insured's Signature

Contract #

Date

General Authorization to Pay Benefits

I hereby authorize payment directly to **Retina Associates of Cleveland, Inc.** for all medical and/or surgical services, if any, otherwise payable to me for services provided by one or more physicians and/or agents of **Retina Associates of Cleveland, Inc.**

Insured's Signature

Date

Do you have one of these credit cards?

MasterCard Yes No

Visa Yes No

Discover Yes No