AKR BWD LK LRN MTR MH STR WRN YT GRN RD
LJS MAN HZ ZNZ SDP DGM JMC JPS LJR LGK SAL

Date ____/____/____

Please print clearly

Patient Information

Marital Status ❒ Married ❒ Single ❒ Widowed ❒ Divorced

Home phone # ____________________

Name ____

Cell phone # ____________________

Address ____

Soc. Sec. # ____________________

City ____

State __________ ZIP ____________

Date of birth ____ / _____ / _____

E-mail address ______________________________________

Sex ❒ Male ❒ Female

Do you live in a nursing facility? ❒ No ❒ Yes

Height ________ Weight _________

Date of admission to nursing facility _____ / _____ / _____

Name of nursing facility ______________________________

Ethnicity ❒ Hispanic or Latino ❒ Not Hispanic or Latino ❒ Patient declined

Language preferred ____ ❒ Patient declined

Race ❒ American Indian or Alaska Native ❒ Asian ❒ Black or African American
❒ Native Hawaiian or other Pacific Islander ❒ White ❒ Patient declined

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 # ____________________

May we leave a message with anyone at your home ❒ *Yes* ❒ *No* or on an answering machine ❒ *Yes* ❒ *No*?

Insurance Information

Please present your insurance cards to be copied.

Primary ____

Secondary ____

In whose name is your insurance carried? ____________________ His/her date of birth ___ / ___ / ___

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 _________

Pharmacy (and address if known) ____

Do you have diabetes? ❒ *Yes* ❒ *No* If yes, name of the physician who manages your diabetes:

____

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 ❒