AKR BWD CTN C.FALLS DVR FAIR LRN MED MTR MH STR WLK WRN YT BRN

LS MAN HZ SDP DGM JMC JPS LJR AFN SAL SMP TPH HP

Today's Date:___/___/____

New Patient Information

Patient Name:_________________________________ Sex:________ Date of Birth:____/____/_____

Social Security #_________________________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address____City____________________Zip_________

Home Phone #____________________ Cell Phone #_____________________

Email Address____

To contact you for appointment reminders (please circle your response): Phone Text Email

Referring Eye Doctor:________________________ City you saw Referring Eye Doctor:_______________

Primary Care Doctor:________________________ City you see Primary Care Doctor:________________

Any other Eye Doctor:____

Emergency Contact:_____________________________ Phone #____________________________

Relationship:__________________________________

Do we have permission to leave a message on devices above or with someone who answer them?

☐ Yes ☐ No

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Language Preferred:____________________________

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Patient Declined

Local Pharmacy:______________________________ City of Pharmacy:____________________________

Present Illness Please describe your current eye problem:

____

____

If the name of the policy holder on the insurance is different than the patient, what is his/her date of birth? _______________

Information Release / Emergency Contact

I, ___________________, authorize Retina Associates of Cleveland, Inc. to release to the individual(s) listed below information regarding my care, including office visits, medical information, testing, and billing.

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Patient Signature	Witness	Date

Authorization to Release Information & To Pay Benefits

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 or companies for claims processing.

I hereby authorize payment directly to Retina Associates of Cleveland 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.

Patient Signature ______________________ Date ______________

I have received the notice of Privacy Practices: ☐ **Yes** ☐ **No**

Patient 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 authorized 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 during the full period of my treatment by any of the physicians and/or agents of Retina Associates.

Patient Signature	Medicare Number	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 covered under my contract for services provided by one or more physicians and/or agents of Retina Associates of Cleveland, Inc.

Patient Signature	Contract Number	Date