



### PATIENT INFORMATION

PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
(FIRST) (MIDDLE INITIAL) (LAST)

**CONTACT INFORMATION**

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

CELL PHONE \_\_\_\_\_ OTHER (SEASONAL) \_\_\_\_\_

**AT WHICH NUMBER WOULD YOU PREFER TO RECEIVE AUTOMATED APPOINTMENT REMINDERS?**

HOME  CELL  WORK  OTHER (SEASONAL)

MAILED ADDRESS \_\_\_\_\_

SEASONAL ADDRESS \_\_\_\_\_

EMAIL \_\_\_\_\_

**PERSONAL INFORMATION**

BIRTH DATE \_\_\_\_\_ SEX:  M  F MARITAL STATUS:  MARRIED  SINGLE  WIDOWED

LANGUAGE:  ENGLISH  SPANISH  FRENCH  OTHER: \_\_\_\_\_

**THE FOLLOWING INFORMATION IS REQUESTED BY MEDICARE:**

RACE:  AMERICAN INDIAN  BLACK OR AFRICAN AMERICAN  CAUCASIAN

OTHER \_\_\_\_\_  DECLINE TO REPORT

ETHNICITY:  HISPANIC  LATINO  NOT HISPANIC OR LATINO  DECLINE TO REPORT

**EMERGENCY CONTACT(S)**

NAME OF EMERGENCY CONTACT \_\_\_\_\_

PHONE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

SECOND EMERGENCY CONTACT (OPTIONAL) \_\_\_\_\_

PHONE \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

**DOCTOR INFORMATION**

EYE DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_



PATIENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
(FIRST) (MIDDLE INITIAL) (LAST)

**PRIMARY INSURANCE INFORMATION**

INSURANCE CARRIER \_\_\_\_\_ PHONE \_\_\_\_\_

ID# \_\_\_\_\_ GROUP # \_\_\_\_\_

**IF THE SUBSCRIBER IS DIFFERENT FROM THE PATIENT:**

SUBSCRIBER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE CARRIER \_\_\_\_\_ PHONE \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

**IF THE SUBSCRIBER'S NAME IS DIFFERENT FROM THE PATIENT:**

SUBSCRIBER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

**IS THE PATIENT IN A SKILLED NURSING FACILITY?  YES  NO**

**IF YES, PLEASE GIVE THE NAME OF THE SKILLED NURSING FACILITY \_\_\_\_\_**

**IS THIS A WORKER'S COMPENSATION CLAIM?  YES  NO**

**IF YES, PLEASE SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK.**

**MEDICARE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:**

I request that payment of authorized Medicare benefits be made on my behalf to Retina-Vitreous Surgeons of Central NY, P.C. for any services rendered by a physician of the group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information to determine these benefits payable for related services.

**PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE:**

I authorize payment of medical benefits to Retina-Vitreous Surgeons of Central NY, P.C. for any services rendered by a physician of the group. I understand that I am financially responsible for any amount not covered by my contract. I also authorize the release to my insurance company or their agent information concerning health care, advice, or treatment provided. This information will be used for the purpose of evaluating and administering claims of benefits.

I have read and completed this document to the best of my ability, and I understand and agree to all the terms and conditions.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
(PRINTED NAME IF LEGAL GUARDIAN)

\_\_\_\_\_  
(RELATIONSHIP TO PATIENT)