REGIONAL RETINA

DAVID H. REN, M.D., Ph.D.

REGISTRATION FORM

Patient Name : _____ Home Phone : _____

Address : _____

Date of Birth: _____ SS#: _____ Sex: []F[]M Marital Status: _____

Day Phone : _____ Emerg Contact & Phone: _____

Employer : _____ Work Phone : _____

Primary Insurance : _____ ID#: _____

Secondary Insurance : _____ ID#: _____

PLEASE HAVE YOUR INSURANCE CARD AND ONE OTHER ID AVAILABLE FOR OUR FRONT DESK

PRIMARY INSURANCE POLICY HOLDER (if different from above) :

Name : _____ Address : _____

Relationship : _____ SSN : _____ DOB : ____/____/_____

Employer : _____ Work Phone : _____

SECONDARY INSURANCE POLICY HOLDER (if different from above) :

Name : _____ Address : _____

Relationship : _____ SSN : _____ DOB : ____/____/_____

Employer : _____ Work Phone : _____

FINANCIALLY RESPONSIBLE PARTY (if different from above) :

Name : _____ Relationship : _____

SSN : _____ Home Phone : _____ Work Phone : _____

Address: _____

PRIMARY CARE PHYSICIAN : _____ Phone No. : _____

REFERRING PHYSICIAN : _____ Phone No. : _____

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payment for office services is due on the day of service. As part of our service we will submit your insurance claims. Insurance/Financial arrangements should be made with our Patient Relations Dept. prior to SURGERIES.

RELEASE OF INFORMATION and ASSIGNMENT OF BENEFITS DECLARATION:
I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from MEDICARE and/or other insurance provider(s) for services rendered. I understand and agree to the above conditions.

Date _____ Signature _____

HIPAA PRIVACY RIGHTS AND AUTHORIZATION FOR DISCLOSURE OR PROTECTED HEALTH INFORMATION:
I have read the HIPAA rights and authorization statements and give my consent for disclosure of my medical records related to treatment.

Date _____ Signature _____