

Patient/Responsible Party Information

Responsible Party Name_____

Date of Birth_____ SSN_____

Relationship to Patient (Circle) Self Spouse Parent/Guardian Other_____

Home Phone_____ Work Phone_____

Home Address_____

City_____ State_____ Zip_____

Employer_____

Employer Address_____

City_____ State_____ Zip_____

Occupation_____

Appt Date _____	Time _____	Dr _____	Office Use Only (HIPAA-9/12/02) Office _____
Requested By _____	Dr.# _____	Dr Phone _____	

Name _____ Sex M F

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Date of Birth _____

SSN _____ DL# _____

Employer _____ Work Phone _____

Employer Address _____

Primary Care Doctor _____ Doctor Phone _____

Doctor Address _____ City _____ Zip _____

Emergency Contact Name _____ Relationship _____

Contact Phone _____ Does patient need a translator? Yes No

Insurance Information (Please give all cards to the receptionist)

Primary Insurance _____ Secondary Insurance _____

Medical Group _____ Auth Needed? Yes No

Auth/Ref# _____ Requested by _____

Authorization for: consult treatment FA/FP other _____

Is your illness work related? Yes No Auto Accident? Yes No

Is anyone other than you responsible for payment? Yes No If yes complete reverse side

I give my permission for Bay Area Retina Associates to communicate information regarding my health, care and progress to the individual(s) listed here:

1. _____ Relationship _____

2. _____ Relationship _____

Signature _____ Date _____

I decline to designate a specific individual to have information about my health, care and progress.

Signature _____ Date _____

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Bay Area Retina Associates, and any assisting physicians, for services rendered. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Signature _____ Date _____