Please complete the following information. See a staff member if you need any assistance.

Name: _____
First Middle Last

Gender at Birth: Male Female Gender Identity: _____

Date of Birth: _____/_____/_____

Local Address:

_____
Street City State Zip

Home Phone:(_____) _____ Cell Phone: (____) _____

Mailing Address, if different:

_____
P. O. Box City State Zip

Northern Address:

_____
Street City State Zip

Northern Phone:(_____) _____

E-Mail Address: _____

Permission to leave medical results on answering machine: Yes No

I authorize Advanced Retina Institute to communicate with the following individuals regarding my condition or course of treatment.

Referring Physician: Please provide the address if the physician is not local.

Name Phone Address City, State, Zip

General Eye Care Physician: If different from Referring Physician listed above.

Name Phone Address City, State, Zip

Primary Care Physician:

Name Phone Address City, State, Zip

The following information is collected per Federal Government regulation in the Health Information Technology Act (HITECH ACT). Your response is optional.

Race: *Please circle* American Indian or Alaskan Native Asian

Black or African American Native Hawaiian or Pacific Islander White

Unreported / Not Known

Primary Language Spoken: _____

Ethnicity: *Please circle*

Hispanic or Latino Not Reported Not Hispanic or Latino

Approved Medical Data Release / Emergency Contact information:

1. _____ Relationship_____ Phone: _____

2. _____ Relationship_____ Phone: _____

3. _____ Relationship_____ Phone: _____

Health Insurance Information

Please provide your insurance card(s) to our receptionist.

You only need to complete this page if you did not give insurance cards to the receptionist OR if the primary subscriber is someone other than the patient, please complete all information below.

Primary Insurance Company Name: _____

Claims Address: _____
Address City State Zip

Phone: (_____) _____

Subscribers Name if other than Patient: _____

Subscribers Date of Birth: _____

Subscribers Plan ID number: _____

If Workman Compensation Claim, please provide:

Employer/Company name: _____

Address: _____

Phone: (____) _____

Supplemental Insurance Company Name: _____

Claims Address: _____
Address City State Zip

Phone: (_____) _____

Subscribers Name if other than Patient: _____

Subscribers Date of Birth: _____

Subscribers Plan ID number: _____

Patient Consent and Acknowledgement

I understand Advanced Retina LLC Institute will create medical reports pertaining to the care I receive. I give permission for my healthcare reports to be sent to the provider(s) who referred me to Advanced Retina Institute, as well as those I have listed on this form, and to any provider I am referred to for continued ocular care and treatment.

I understand and consent to Advanced Retina Institute LLC sharing information about me with my insurance company or third-party payment source or their agents and/or employees (including my employer, if this is a worker's compensation claim) to facilitate claim processing and payment for services rendered.

I hereby assign my right to be reimbursed out of any insurance policy or from any person or organization that is or may become liable to me for any, and all costs or fees associated with my care and treatment to Advanced Retina Institute LLC and authorize payment be made directly to Advanced Retina Institute LLC.

I understand and agree that I am individually responsible and obligated to pay for the care and treatment provided to me, including outstanding balances not covered by any insurance policy or third-party payment source such as Medicare or other healthcare plans. I understand and agree that if I do not pay any amounts due, I will be liable for any costs and fees associated with collecting those amounts, including attorney's fee and court costs, if any.

I also understand, Advanced Retina Institute provides necessary care to the community. To ensure the physician can accommodate all patients, should I cancel my appointment I agree to contact the office 24 hours in advance. I understand, and agree, cancelling with less than 24-hour notice, or not showing for my scheduled appointment will result in a $100.00 rescheduling fee, to be paid before my next appointment can be scheduled.

_____ _____

Signature Date