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

Name: ____
First Middle Last

Date of Birth: ____/____/______ Gender at Birth: Male Female

Gender Identity: ______________________________

E-Mail Address: ____

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:(_____) ____________________

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

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

Approved Medical Data Release / Emergency Contact information:

1. ______________________________ Relationship____________ Phone: _____________

2. ______________________________ Relationship____________ Phone: _____________

3. ______________________________ Relationship____________ Phone: _____________

Permission to leave medical results on answering machine: Yes   No

Health Insurance Information

Please provide your insurance card(s) to our receptionist. 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) in order 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, that I will be liable for any costs and fees associated with collecting those amounts, including attorney's fee and court costs, if any.

_______________________________________ ________________________

Signature Date