RETINA SPECIALISTS OF OHIO

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age	Sex: ❑ M ❑ F
Street address:		Social Security no.:			Home phone no.: ( )
P.O. box:	City:		State:		ZIP Code:
Occupation:	Employer:				Employer phone no.: ( )
Chose clinic because/Referred to clinic by (please check one box):		❑ Dr.		❑ Insurance Plan	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card(s) to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):			Home phone no.: ( )
Occupation:	Employer:	Employer address:			Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize you to leave messages, with regard to my appointments and/or medical care, on my answering machine and/or with a family member living in my home. I authorize my insurance benefits be paid directly to the physician/Retina Specialists of Ohio, LLC. I understand that I am financially responsible for any balance. I also authorize Retina Specialists of Ohio, LLC or my insurance company to release any information required to process my claims.

Patient/Guardian signature

Date

RETINA SPECIALISTS OF OHIO

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE (HIPPA)

We care about the pricacy of your health care information. Our policies for protecting your healthcare information are explained in our Notice of Privacy Practices. We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. Please write the names of personal contacts we may share your medical information with. **Please note we can ONLY speak to those listed on this form in regards to your healthcare needs.**

Name _____ **Relationship** _____

Name _____ **Relationship** _____

Name _____ **Relationship** _____

I acknowledge that I have received a copy of Retina Specialists of Ohio Notice of Privacy Practices.

Please Print Your Name

Signature

Date

For Office Use Only

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ○ The patient refused to sign
- ○ Due to an emergency situation it was not possible to obtain acknowledgement
- ○ We were unable to communicate with the patient
- ○ Other (please provide specific details) _____

Employee Signature