PATIENT REGISTRATION FORM

PATIENT INFORMATION **TODAY'S DATE:** _____

Name: _____

Address: _____

City, State, Zip: _____

Preferred Phone: _____ ☐ Home ☐ Cell ☐ Work

Alternate Phone: _____ ☐ Home ☐ Cell ☐ Work

Marital Status:

☐ Married ☐ Single

☐ Divorced ☐ Widowed

Ethnicity:

☐ Not Hispanic or Latino

☐ Hispanic or Latino

☐ Unknown

Race:

☐ White ☐ Black or African American

☐ Asian ☐ American India/Alaskan Native

☐ Native Hawaiian/Other Pacific Islander

☐ Other

Social Security Number: _____

E-Mail Address: _____

Date of Birth: _____Age:_____

PATIENT'S EMPLOYMENT INFORMATION

Employer's Name: _____ ☐ Employed ☐ Retired

Employer's Phone: _____ ☐ Student/Child ☐ Unemployed

Occupation: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____

ID No.: _____

Subscriber Name: _____

Subscriber's SS No.: _____

Relationship to Patient: _____

Subscriber's Date of Birth: _____

SECONDARY INSURANCE INFORMATION

Insurance Company name: _____

ID NO.: _____

Subscriber Name: _____

Subscriber's SS No.: _____

Relationship to Patient: _____

Subscriber's Date of Birth: _____

PATIENT'S PHYSICIAN INFORMATION

Referring Physician: _____

Address: _____

Phone: _____

Primary Care Physician: _____

Address: _____

Phone: _____

FINANCIAL POLICY STATEMENT

Welcome to the Retina Institute of Michigan. We are pleased you have chosen our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following the following policy. If we are contracted with your insurance company, we will accept assignment. All co-pays, co-insurance, and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all payable charges for services being the sole responsibility of the patient of the patient/responsible party. You are expected to understand your benefits coverage and financial responsibility. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service. You will be responsible for any balances not covered by your insurance.

Patient/Guardian Signature: _____ Date: _____