Patient Information Form

Patient Name: ____ Date of Birth: ____/____/____ Age: _____

Social Security No: ______________________________________ Home Phone: ____________________

Street Address: ____

City: ______________________________ State: ______ Zip Code: _______________ Sex: M F

Employer: ____ Work Phone: __________________

Employer Address: _____________________________________ Occupation: ____________________

Spouse/Parent Name: ___________________________________ Phone No: ______________________

Emergency Contact Person: ________________________________ Date of Birth: ____________________
(Someone not living with you)
Emergency Contact Phone: _____________________________ Relation/Role To Patient: ______________

Primary Insurance: _________________________ Policy No: ____________________ Group No: _________

Policy Holder: ___________________________ Relationship: _____________ Date of Birth: _____________

Policyholder's Social Security No: ____

Secondary Insurance: _______________________ Policy No: ____________________ Group No: _________

Policy Holder: ___________________________ Relationship: _____________ Date of Birth: _____________

Policyholder's Social Security No: ____

Family Physician: ____ Phone No: _____________________

Full Address: ____

Optometrist/Ophthalmologist: _____________________________________ Phone No: ________________

Full Address: ____

Referring Doctor: ____ Phone No: ____________________

Full Address: ____

I hereby authorize The National Retina Institute (NRI) to bill my insurance (which may include release of medical information to process this claim). I also authorize payment to be made directly to NRI. In addition, if my account is forwarded to an outside collection agency for collection of a past due balance, I will be responsible for the collection fees incurred by NRI to said outside collection agency. ***YOUR SIGNATURE IS REQUIRED BELOW.***

Signature: ____ Date: ___________________