RETINA CONSULTANTS OF NEVADA

PATIENT INFORMATION

ACCT# _____

PLEASE PRINT CLEARLY

3 8 10 11 12 15 16 17 18

E W GV NW SG LN MQ

Name _____ Date_____
First Last

Home Address _____

City _____ State _____ Zip _____ Home Phone _____

Sex _____ Age _____ Cell Phone _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social Security # _____ Date of Birth _____

Referred by _____ Email Address _____

Employer _____ Occupation _____

Work Address _____

City _____ State _____ Zip _____ Work Phone _____ Ext. _____

Insured's Name & Address _____ Phone _____

Employer _____ Occupation _____

Work Address _____ Work Phone _____

City _____ State _____ Zip _____ _____ Ext. _____

Insured's Social Security # _____ Date of Birth _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name _____ Relationship_____ Phone _____

Address _____ City _____ State _____ Zip _____

Primary Care Physician's Name _____

Address _____Phone _____

PLEASE TURN OVER

Ver. Nov2019

I WILL BE PAYING TODAY BY:

(CHECK ONE)

☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ INSURANCE

PLEASE READ CAREFULLY AND SIGN

I understand that every visit my eyes will be dilated. I understand that it is legal to drive dilated, but I may be more comfortable if I have a driver.

I understand that I am financially responsible for all charges incurred.

I request that payment of authorized insurance benefits be made to Retina Consultants of Nevada for any services furnished to me.

A handling fee will be charged for personal checks returned from the bank for any reason.

This consent acknowledges and permits Retina Consultants of Nevada to use and disclose Protected Health Information (PHI) to carry out treatment, payment or healthcare operations.

Retina Consultants of Nevada contacts patients by phone call, email and/or text message.

Consent to opt-in for communication via: ☐ Email ☐ Text Message

_____ _____

Patient's Signature Date