

Retina and Vitreous Associates of Kentucky

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PATIENT REGISTER

PATIENT'S NAME _____ Age _____ Date: _____

(Please Print)

Race _____ Sex _____ Social Security # _____ Birthdate _____

Single Married Separated Divorced Widowed

Home Address: _____
Street _____ City _____ St. _____ Zip _____

Home Phone _____ Cell Phone _____ Business Phone _____ Occupation _____

Employer _____ Address _____

Active Retired
Spouse _____ Social Security # _____

Nearest Relative _____ Relationship _____ Phone _____
(Not living with you)

REFERRING DOCTOR _____

Name _____ City _____
Address _____

PERSON RESPONSIBLE FOR BILL:

Name _____ Social Security # _____ Telephone _____

Address _____

Where employed _____ Occupation _____

Relationship to patient _____

MEDICAL INSURANCE (Numbers Please) Subscribers Name: _____ D.O.B. _____

Employed by: _____ Phone: _____

Blue Shield _____ Medicaid _____ Medicare _____ Other _____ BGFH _____ CHA _____ UHC _____

PATIENT'S AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND CLAIM PAYMENT INFORMATION

I hereby authorize the above physician(s) to release any information regarding services rendered by him/her and allow a photocopy of my signature to be used.

_____ Date

_____ Patient (Parent or Guardian if Minor)

I hereby authorize and direct my insurer to issue payment check(s) for benefits due me for the services rendered by the above named physician(s) to be made directly to him/her. Regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for services rendered. **All fees are due within 30 days from date of services rendered.**

_____ Date

_____ Responsible person/policy owner insured

_____ Social Security #

I prefer to pay my account with Cash Check Visa/Mastercard Other

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIAN AND PATIENT

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize my holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related medical claim. I request the payment of authorized benefits be payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to medicare for payment to me.

I request that payment under the Medical Insurance Program be made either to me or to the above named physician(s).