RETINA ASSOCIATES OF KENTUCKY

For office use only

ACCT#: _____

PATIENT REGISTRATION FORM

(Please Print)

DATE:_____ **NAME:** _____ **SS#:** _____

☐ **M** ☐ **F** **BIRTHDATE:** _____ **AGE:** _____ ☐ **SINGLE** ☐ **MARRIED** ☐ **DIVORCED** ☐ **WIDOWED**

HOME ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE #: _____ **CELL PHONE #:** _____

ALTERNATE PHONE #: _____ **NAME / RELATION:** _____

EMAIL ADDRESS: _____ **BEST DAY PHONE:** ☐ **HOME** ☐ **CELL** ☐ **ALT.** ☐ **WORK**

EMPLOYER: _____ **PHONE #:** _____

EMERGENCY CONTACT NAME / RELATION:_____ **PHONE #:** _____

WHO REFERRED YOU TO OUR OFFICE? _____ **PHONE #:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE #:** _____

PREFERRED PHARMACY: _____ **PHONE #:** _____

COMPLETE IF PATIENT IS A MINOR OR HAS A POWER OF ATTORNEY (POA)
PARENT / GUARDIAN / POA INFORMATION ☐ **POA DOCUMENTS SCANNED**

NAME: _____ BIRTHDATE: _____

SS#: _____ PHONE #: _____ RELATION: _____

As part of healthcare reform, our practice collects demographic data to aid health agencies understand healthcare disparities, improve quality of care, and strengthen research and outreach. We appreciate your assistance in meeting these new national standards. Please mark the most accurate description.

Race:	Preferred Language:	Ethnicity:
___ American Indian or Alaska Native	___ English	___ Hispanic or Latino
___ Asian	___ Spanish	___ Not Hispanic or Latino
___ Black or African American	___ Other:	___ Decline to participate
___ Native Hawaiian or Other Pacific Islander	_____	
___ Caucasian / White		
___ Multiracial		
___ Decline to participate		

PRIMARY INSURANCE: _____	**SECONDARY:** _____
GROUP #: _____	**GROUP #:** _____
ID#: _____	**ID#:** _____
SUBSCRIBER: _____	**SUBSCRIBER:** _____
SUBSCRIBER BIRTHDATE: _____	**SUBSCRIBER BIRTHDATE:** _____
SUBSCRIBER SSN: _____	**SUBSCRIBER SSN:** _____
RELATION TO SUBSCRIBER: _____	**RELATION TO SUBSCRIBER:** _____

CONSENT TO TREATMENT
I authorize the rendering of treatment, services and procedures, by authorized agents and employees of Retina Associates of Kentucky.

ASSIGNMENT OF BENEFITS
I hereby assign all rights and authorize payment directly to Retina Associates of Kentucky for any claim filed on the above-named patient's behalf. I understand that I am financially responsible to Retina Associates of Kentucky for charges not covered by an assignment of benefits or paid on a timely basis by an insurance company.

RELEASE OF INFORMATION
I authorize the release of information from the above-named patient's records to any payer, including insurance companies or government agencies, as required by such payer for payment, peer review, or quality assurance purposes.

PAYMENT GUARANTEE
I agree to be responsible for payment in full of charges resulting from treatment or services rendered. Should I fail to make payment in full, I agree to pay any additional collection costs or attorney fees associated with collection of my account. No granting of extensions or delays in collection efforts shall constitute a forgiveness of amounts due. I agree that Retina Associates of Kentucky is not a party to any disputed claim or peer review decision which affects payment of claim filed upon my behalf and upon request for payment I agree to pay any outstanding balance. Further, I understand that I may be contacted regarding payment using any information provided elsewhere within my record.

I certify that I have read and agree with the above statements, agreements and authorizations. Further, I certify that all information provided is true and accurate. This consent will remain valid until I revoke it.

_____ **Date:** _____
Patient/Guardian Signature

_____
Print Patient Name