

RETINA ASSOCIATES OF NEW JERSEY, P.A.

PATIENT REGISTRATION FORM

PATIENT DATA	PATIENT LAST NAME		FIRST	MI	() FEMALE () MALE	BIRTH DATE	AGE	HOME PHONE		
	ADDRESS			CITY		STATE	ZIP			
	SS#	LICENSE#		WORK#		OCCUPATION	MARITAL STATUS			
							S	M	W	D
	EMPLOYER NAME / ADDRESS			CITY		STATE	ZIP			
	REFERRING PHYSICIAN NAME AND ADDRESS				PRIMARY CARE PHYSICIAN NAME AND ADDRESS					
INSURANCE	PRIMARY INSURANCE- NAME AND ADDRESS									
	POLICY #			GROUP #			EFFECTIVE DATE			
	POLICY HOLDER NAME				DOB		SSI#			
	RELATIONSHIP TO PATIENT									
	SECONDARY INSURANCE- NAME AND ADDRESS									
	POLICY #			GROUP #			EFFECTIVE DATE			
	POLICY HOLDER NAME				DOB		SSI#			
	RELATIONSHIP TO PATIENT									
WORKMENS COMP.	IS THIS WORK RELATED ()Y ()N		DATE OF INJURY		CLAIM #					
	WORKMANS COMP. INSURANCE AND ADDRESS									
	ATTORNEY NAME AND ADDRESS									

UNIFORM OF ASSIGNMENT, RELEASE OF INFORMATION AND FINANCIAL DISCLOSURE:

ASSIGNMENT OF BENEFITS:

I hereby assign or transfer payment benefits made to me and my behalf to Retina Associates of NJ, P.A. for any services furnished to me by this physician/supplier. I further agree that I am responsible for payment of charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

FINANCE CHARGE:

A finance charge of 1.5% (18% annually) will be imposed on each item of your account which has not been paid within 60 days.

RELEASE OF INFORMATION:

I hereby authorize Retina Associates of NJ, PA to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If Medicare patient, I further authorize release to the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

Patient Signature _____ Date _____