

**RETINA ASSOCIATES OF NEW JERSEY, P.A.
PATIENT REGISTRATION FORM**

PATIENT DATA	PATIENT LAST NAME		FIRST	MI	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	BIRTH DATE	AGE	HOME PHONE	
	ADDRESS				SOCIAL SECURITY NO.		MARITAL STATUS: S M W D		WORK PHONE
	CITY	STATE	ZIP	ARE YOU EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO		EMPLOYER NAME		OCCUPATION	
	EMPLOYER ADDRESS							PHONE	
	WHO CAN WE CONTACT IF WE ARE UNABLE TO REACH YOU?						RELATIONSHIP	PHONE #	
INSURANCE	INSURANCE COMPANY PRIMARY			EFFECTIVE DATE	INSURANCE COMPANY SECONDARY			EFFECTIVE DATE	
	ADDRESS (WHERE CLAIMS ARE TO BE SENT)				ADDRESS (WHERE CLAIMS ARE TO BE SENT)				
	CITY	STATE	ZIP	CITY	STATE	ZIP			
	POLICY/ID #	GROUP #	PHONE #	POLICY/ID #	GROUP #	PHONE #			
	POLICYHOLDER: _____			MEDIGAP/CROSSOVER YES - NO					
	SS # _____			POLICYHOLDER: _____					
DATE OF BIRTH _____ SEX _____			DATE OF BIRTH _____ SEX _____						
RELATIONSHIP TO PATIENT _____			RELATIONSHIP TO PATIENT _____						
WORKMENS COMP.	IS THIS INJURY WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO		DATE OF INJURY:		DOES YOUR EMPLOYER KNOW? <input type="checkbox"/> YES <input type="checkbox"/> NO				
	IF YES, WORKMENS COMP. INS. CARRIER NAME AND ADDRESS: (WHERE TO SEND CLAIMS) CITY, STATE, ZIP							PHONE#	
	EMPLOYER NAME & ADDRESS: (WHEN INJURY OCCURRED) CITY, STATE, ZIP					INJURY CLAIM #	EMPLOYER POL. #		

REFERRING PHYSICIAN _____
 ADDRESS _____

 PHONE _____

PRIMARY CARE PHYSICIAN _____
 (HMO PATIENTS ONLY)
 ADDRESS _____

 PHONE _____

Uniform assignment and release of information statement.

I hereby assign or transfer payment benefits made to me or on my behalf to Retina Associates of New Jersey, 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 outside of the scope of my insurance coverage or for which my insurance company has paid me.

I hereby authorize Retina Associates of New Jersey, P.A. to release information acquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services.

Date _____

Account # _____

Patient Signature _____