Retina Specialists
of Michigan

Date: _____

Patient Registration

PATIENT INFORMATION *(Please Print)*

NAME _____ PREFERS TO BE CALLED _____

ADDRESS _____ HOME PHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

DATE OF BIRTH _____ AGE _____ ☐ MALE ☐ FEMALE SS# _____-_____-_____

EMAIL ADDRESS _____

ORIGIN: ☐ HISPANIC / ☐ NON HISPANIC ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

RACE: ☐ WHITE ☐ ASIAN ☐ AFR AMER ☐ AMER INDIAN ☐ NATIVE HAWAIIAN PREFERRED LANGUAGE: _____

IF PATIENT IS A CHILD:

PARENT/GUARDIAN NAME _____ RELATIONSHIP _____

ADDRESS _____ DATE OF BIRTH _____

GETTING TO KNOW YOU

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____ PHONE # _____

POA _____ If applicable, please provide copy of legal papers.

DO YOU LIVE IN A TEMPORARY SKILLED NURSING HOME, REHAB CENTER, ETC.? TYPE OF FACILITY _____

NAME OF FACILITY _____ PHONE # _____

ADDRESS _____

ALTERNATE/WINTER ADDRESS & PHONE _____

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT ☐ PATIENT ☐ OTHER

NAME _____ RELATIONSHIP _____ SS# _____-_____-_____

ADDRESS _____ PHONE # _____

MEDICAL INSURANCE

DO YOU HAVE MEDICAL INSURANCE COVERAGE? ☐ YES ☐ NO

PRIMARY INSURANCE

INSURANCE NAME _____

CONTRACT / ID # _____

EMPLOYER _____

SUBSCRIBER INFORMATION IF DIFFERENT THAN PATIENT

NAME _____ DOB _____

RELATIONSHIP TO PATIENT _____

SSS# _____-_____- _____

SECONDARY INSURANCE

INSURANCE NAME _____

CONTRACT / ID # _____

EMPLOYER _____

SUBSCRIBER INFORMATION IF DIFFERENT THAN PATIENT

NAME _____ DOB _____

RELATIONSHIP TO PATIENT _____

SSS# _____-_____- _____

Please turn over and sign

Retina Specialists
of Michigan

5030 Cascade Road, SE
Grand Rapids, MI 49546

Phone (616) 954-2020

RELEASE OF INFORMATION & FINANCIAL RESPONSIBILITY FOR MEDICARE CLAIMS

Patient Name: _____

Medicare Number: _____

I request that payment of authorized Medicare benefits be made on my behalf to Retina Specialists of Michigan, P.C. for any services furnished to me by a physician of Retina Specialists of Michigan, P.C. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that my insurance company will be billed and that I am responsible for all co-payments, co-insurances and deductibles not covered by insurance.

I also authorize Retina Specialists of Michigan, P.C. to release any and all medical information contained within my medical records to referring physicians, consulting physicians, hospitals, laboratories, therapists, pain clinics, or a specifically named location in the course of treatment under Retina Specialists of Michigan, P.C. This information may include physical condition, diagnostic study results, diagnosis, prognosis and/or treatment plan. It may also include drug abuse, alcohol abuse, HIV, AIDS and / or psychological information.

Patient Signature:_____ Date: _____

This authorization is in effect until I revoke it.

RELEASE OF INFORMATION & FINANCIAL RESPONSIBILITY FOR COMMERCIAL/MEDICAID CLAIMS

I hereby authorize my insurance benefits to be paid directly to Retina Specialists of Michigan, P.C. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that my insurance company will be billed and that I am responsible for all copayments, co-insurances and deductibles not covered by insurance.

I also authorize Retina Specialists of Michigan, P.C. to release any and all medical information contained within my medical records to referring physicians, consulting physicians, hospitals, laboratories, therapists, pain clinics, or a specifically named location in the course of treatment under Retina Specialists of Michigan, P.C. This information may include physical condition, diagnostic study results, diagnosis, prognosis and / or treatment plan. It may also include drug abuse, alcohol abuse, HIV, AIDS and / or psychological information.

Patient Signature:_____ Date: _____