



TAYLOR RETINA CENTER, P.A.

PATIENT INFORMATION FORM
PLEASE PRINT CLEARLY

Patient Name: Male Female

Birth Date: Social Security #

Race: (check one) American Indian/Alaska Native Asian Black or African American White
Native Hawaiian or other Pacific Island Other Decline

Ethnicity: (check one) Hispanic or Latino Not Hispanic or Latino Decline

Preferred Language: English Spanish Other:

Patient Address:

City: State: Zip:

Home Phone: Cell Phone:

Employer Name:

Employer Address:

Number Street

City: State: Zip:

Spouse's Name: Spouse's Work Number:

Spouse's Birth Date:

EMERGENCY CONTACT (Someone not living with you)

Name: Relationship:

Home Phone: Work Phone:

INSURANCE INFORMATION

Please have your insurance cards ready for us to copy

Primary Insurance Co. Name:

Subscriber's Name: DOB:

Policy Number: Group #:

Secondary Insurance Co. Name:

Subscriber's Name: DOB:

Policy Number: Group #:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare or Commercial insurance by phone, mail or fax. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments. I understand it is mandatory to notify the health care provider or any other party who may be responsible for paying for my treatment. (Section 1128 B of the Social Security Act and 12 U. S. C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply. This authorization is in effect until I choose to revoke it.

I understand that if my insurance denies payment or if I have no insurance coverage, that I am financially responsible.

DATE: _____ SIGNED: _____

(Patient or Legal Guardian)

PRIMARY INSURANCE

SECONDARY INSURANCE

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy/read a copy of the Notices of Privacy Practice for the Taylor Retina Center.

Signature: _____ Date: _____

For Office Use Only:

We were unable to obtain a written acknowledgment of receipt of the Notice of Privacy Practices because:

- An emergency existed & a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature by return mail.
- Unable to communicate with the patient for the following reason: _____

Prepared by: _____ Signature: _____ Date: _____