Mississippi Retina ASSOCIATES

PATIENT INFORMATION

Name_____
First Middle Last

Date of Birth____/____/____ Home Phone (____) _____ Alternate Phone (____) _____

Mailing Address_____

_____
City State Zip County

Sex (circle) Male Female Marital Status (circle) S M W D Race/Ethnicity_____

Referring Physician_____ Address/Location_____

Family Physician_____ Address/Location_____

Social Security #_____ Employer_____
Name Address

Emergency Contact_____ Emergency Phone #_____
Name Relationship

Spouse's Name_____ Spouse's Date of Birth_____

Spouse's Employer_____
Name Address Phone #

Responsible Party_____
Complete if patient is a minor. Name Address Phone #

Relationship to Patient_____

INSURANCE INFORMATION

Primary Insurance Carrier_____
Name Address Phone #

Insured Name_____ Insured Date of Birth_____

Policy #_____ Group #_____

Secondary Insurance Carrier_____
Name Address Phone #

Insured Name_____ Insured Date of Birth_____

Policy #_____ Group #_____

Is this Worker's Comp? (circle) Yes No If yes, date of injury_____

ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

I request that payment of authorized Medicare/Other insurance company benefits be made to Mississippi Retina Associates, P.A. for any services furnished to me by the party/physician who accepts the assignment. I understand that it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. Section 1128B of the Social Security Act and 31 U.S.C 3801-3812 provides penalties for withholding this information. Regulations pertaining to Medicare assignment of benefits apply. 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 carrier or any other insurance company any information needed for this or a related Medicare/Other Insurance company or related Medigap claim. I permit a copy of this authorization to be used in place of the original.

Signature_____ Date_____

Mississippi Retina ASSOCIATES

Chart No._____

HIPPA ACKNOWLEDGEMENT

By my signature below, I acknowledge that I have received a
Notice of Privacy Practices of Protected Health Information
from Mississippi Retina Associates, P.A.

Signature_____ Date_____

I authorize Mississippi Retina Associates, P.A. to discuss
my medical condition and care with the following person(s):

(1)_____ Relationship_____

(2)_____ Relationship_____

(3)_____ Relationship_____

Signature_____ Date_____