SOUTHEASTERN RETINA SPECIALISTS

Patient Name: _____ **DOB:** _____

Street Address: _____ **Gender:** _____

City, State, Zip: _____ **Home Phone #:** _____

Marital Status: ☐ S ☐ M ☐ D ☐ W ***Cell Phone #:** _____

Do you authorize Southeastern Retina Specialists to send you appointment notifications via text messaging?* ☐ ***Y* *or* ☐ ***N***

Social Security #: _____ **Work Phone #:** _____

E-Mail Address: _____

Employer Name: _____ **Employer Phone #:** _____

Is this appointment the result of an accident or injury? ☐ **Y*** or ☐ **N**

*If Yes, please provide the claim # and adjustor information for this appointment.

Note: The information requested below is a reporting requirement of the government Patient Protection and Affordable Care Act 2010. We are obligated to obtain this information from our patients.

Race:

- ☐ White
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other - _____

Ethnicity:

- ☐ Hispanic
- ☐ Not Hispanic
- ☐ Other - _____

Preferred Language:

- ☐ English
- ☐ Other - _____

Primary Insurance

Carrier Name: _____ **Insurance ID #:** _____

Carrier Phone #: _____ **Group #:** _____

Carrier Address: _____

Are you the SUBSCRIBER **or the** DEPENDENT **for this plan?** _____

Secondary Insurance

Carrier Name: _____ **Insurance ID #:** _____

Carrier Phone #: _____ **Group #:** _____

Carrier Address: _____

Are you the SUBSCRIBER **or the** DEPENDENT **for this plan?** _____

If you are the DEPENDENT **on any insurance plan listed above, please complete the following information:**

Subscriber Name: _____ **Relationship:** _____

Subscriber DOB: _____ **Subscriber SSN:** _____

Emergency Contact

Name: _____ **Phone #:** _____ **Relationship:** _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private or government insurance and other health plans to the party who accepts assignment. I authorize payment of medical benefits to undersigned physician or supplier for service(s) described. This assignment will remain in effect until revoked by me in writing. I authorize the release of any medical or other information necessary to process this claim.

_____ _____

Signed (Insured or Authorized Individual) **Date**