PERSONAL HISTORY

PATIENT INFORMATION

Name ____ Email ________________________________

S.S. # ____ Date of Birth ________________ Age _______

Home Address ____

City, State & Zip ____

Home Phone ______________________________ Cell Phone ______________________________

Check One: Single ________ Married ________ Divorced ________ Widowed ________

Occupation ____

Employer Name & Address ____

Work Phone ____

Emergency Contact ______________________________ Relationship ______________________

Emergency Contact Phone Number ____

Have you or any other member of your family ever been a patient here? ____________________

If yes, name of family member _________________________________ How long ago? ________

Name & Address of Referring doctor ____

Name & Address of Medical doctor ____

Power of Attorney ______Yes ______No, If Yes ______Medical ______Financial _____Both

Name ____________________________________ Phone # ___________________

BILLING INFORMATION

Person responsible for bill: _____Self ___________Other

Name, Address and Phone # ____

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INSURANCE INFORMATION

Please bring your insurance card(s) and copay - Copay due at time of service.

Primary Insurance

Company Name _______________________________________ ID# __________________________

Policy Holders Name ___________________________________ Date of Birth ___________________

Secondary Insurance

Company Name _______________________________________ ID# __________________________

Policy Holders Name ___________________________________ Date of Birth ___________________

AUTHORIZATION - Please read and sign:

I hereby authorize the release of any and all medical records and/or other information pertaining to my medical condition or treatment in the possession of The Retina Group of Northeast Ohio,Inc. to any insurance carrier, and any agent thereof, collecting payment and all medical services rendered by The Retina Group of Northeast Ohio,Inc. I also request payment of medical benefits to the The Retina Group of Northeast Ohio,Inc. for services rendered. I further acknowledge my email account may be a recipient of my protected health information or any correspondence related thereto.

____ Date ______________________

Signature of Patient