PATIENT INFORMATION **Today's Date** _____

Name: _____**Cell Phone**: _____**Home**: _____

Address: _____**City** _____ **Zip** _____

Birth Date: _____**Social Security #** _____ **Preferred Language** _____

Marital Status: _____ E-mail Address: _____

Please circle all that apply:

Race: American Indian or Alaska Native
Black or African American
White
Asian or Pacific Islander
Unknown

Ethnicity: Hispanic or Latino
Not Hispanic or Latino

Gender: Female
Male

If patient is under the age 18, list parent/guardian and SS# _____

Employer: _____ Employer Telephone # _____

Name of Spouse _____ Spouse's Employer _____

Who may we contact in case of an emergency? _____**Phone #** _____

Relationship _____**Who is financially responsible for this bill?** _____

How did you choose our practice? _____

Referring Physician _____ **Phone #** _____

Primary Care Physician _____ **Phone #** _____

Reason for Visit: _____

Do you have an injury that you feel is employment related? _____

List any medications to which you are allergic _____

Primary Insurance Information:

Company Name: _____

Insured's Name: _____

SS# _____DOB _____

Policy # _____Grp # _____

Secondary Insurance Information:

Company Name: _____

Insured's Name: _____

SS# _____ DOB _____

Policy # _____ Grp# _____

List any additional Insurance Carriers _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFORMATION TO INSURANCE COMPANIES LISTED ON THIS FORM

I, _____, hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare and other Government sponsored programs, private insurance and other Health plans to Brown Retina Institute.

This Assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment of said benefits, to include medical records.

If I am the parent or guardian of the patient who is a minor or if I am authorized to act for a patient who is otherwise not competent to consent to treatment, I authorize treatment on the patient's behalf.

I understand that I may be given a return appointment in order to follow-up on my ocular status or condition. In the event that, for any reason, I do not keep that return appointment I agree not to hold Brown Retina Institute, it's physician and/ or staff responsible for any resulting consequences.

Appointments cancelled or missed with less than 24 hours notice will be charged a fee of $25.

Signature _____ Date _____

_____ Self _____ Parent or Guardian of Minor Child _____ Acting on behalf of Patient