THE RETINA CENTERS OF WASHINGTON – NEW PATIENT FORM

Patient's Last name		First name		MI:	
Address:					
City		State code		Zip code	
Social sec. #		Sex (M/F):		Status:	S/M/D/W
Date of birth		Referral Dr.			
Home phone		Work phone			
Emergency		Emer. phone			
Email		Cell phone			
===Primary Insurance Coverage===		**===Secondary Insurance Coverage===**			
Company		Company			
Insured name		Insured name			
Relationship	D.O.B.:	Relationship		D.O.B.:	
Co-pay amount		Co-pay amount			
Policy number		Policy number			
Group number		Group number			
Employer		Employer			
Guarantor Information					
Guarantor					
Address					
City		State code		Zip code	
Phone #		Miscellaneous			

Patient's Authorization

I authorize THE RETINA CENTERS WASHINGTON to apply for benefits on· my behalf for services rendered by THE RETINA CENTERS WASHINGTON. I request payment from my insurance company be made directly to THE RETINA CENTERS WASHINGTON.
I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original.
This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

______________________________ ______________________________

Signature of Subscriber or Beneficiary Date