The Retina Centers of Washington - Patient Registration Form

Patient Information:			
Last Name:	**First Name:**		**M.I:**
Date of Birth:	**Sex (M/F):**	**Social Security # (SSN):**	
Marital Status (S/M/D/W):		**Email Address:**	
Mailing Address:			**APT#:**
City/State/Zip:			
Home Phone:	**Cell Phone:**	**Work Phone:**	
Primary Care Physician:		**Preferred Pharmacy:**	
Primary Care Physician Phone:		**Preferred Pharmacy Phone:**	
Referring Physician:		**Emergency Contact Name / Relationship to Patient:**	
Employer Name & Phone:		**Emergency Contact Phone:**	

Primary Medical Insurance:	Secondary Medical Insurance:
Insurance Company Name:	**Insurance Company Name:**
Policy Holder's Name:	**Policy Holder's Name:**
Policy Holder's Date of Birth:	**Policy Holder's Date of Birth:**
Policy Holder's Social Security #:	**Policy Holder's Social Security #:**
Patient Relationship to Policy Holder:	**Patient Relationship to Policy Holder:**

Guarantor Information (Responsible Party):			
Last Name:	**First Name:**		**M.I:**
Date of Birth:	**Social Security #:**	**Phone:**	
Mailing Address of Person Responsible:			
City/State/Zip:		**Relationship to Patient:**	

I authorize **The Retina Centers of Washington** to apply for benefits on my behalf for services rendered by me. I hereby authorize payments directly to The Retina Centers of Washington, including any benefits otherwise payable to me under the terms of my policy, but not to exceed the balance due to The Retina Centers of Washington for services rendered to me during the applicable period of medical care

I certify that the information I have provided above to be correct. I further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this registration form to be used in place of the original. This authorization may be rescinded by me at any time in writing.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 by The Retina Centers of Washington, when a statement is rendered.

Patient Name: _____ **Date:** _____

Patient Signature: _____