East Coast Retina, PA

Patient Information

PATIENT NAME_____

MAILING ADDRESS_____

CITY/STATE/ZIP_____

PHONE # (Home)_____**(Work/Cell)**_____

BIRTH DATE_____**AGE**_____ **MALE FEMALE**

PATIENT SS#_____ **SINGLE MARRIED DIVORCED WIDOWED SEPARATED**

SPOUSE NAME_____**SS#**_____**DOB**_____

GUARDIAN NAME (If under age 18)_____

GUARDIAN SS# _____**DOB**_____

EMERGENCY CONTACT_____

RELATION_____**PHONE #**_____

PRIMARY CARE PHYSICIAN_____

ADDRESS_____**CITY**_____

PHONE #_____

WHO REFERRED YOU TO OUR PRACTICE? _____

ARE YOU CURRENTLY IN A SKILLED NURSING FACILITY? YES NO

IF YES, NAME OF FACILITY_____

ARE YOU INTERESTED IN ACCESSING THE PATIENT PORTAL? YES NO

IF YES, PLEASE PROVIDE YOUR EMAIL ADDRESS:_____

Preferred Language: (Please circle)

--- English
--- Spanish
--- Other_____

Ethnicity: (Please circle)

--- Not Hispanic or Latino
--- Hispanic or Latino
--- Unknown

Race: (Please circle)

--- American Indian or Alaska Native
--- Asian
--- Black or African American
--- Hispanic/Latino
--- Caucasian/White
--- Native Hawaiian or Other Pacific Islander
--- Multiracial
--- Decline to Specify
--- Unknown

INSURANCE INFORMATION

Primary Insurance_____ Secondary Insurance_____
Please give your insurance cards and a picture ID to the receptionist to make a copy. We require a picture ID to file your insurance.

Claims will be filed for payment with those insurance plans which East Coast Retina is a contracted participating provider. Co-insurance amounts, non-covered amounts, and deductible amounts will be collected at the time of service.

I hereby request evaluation and treatment necessary by East Coast Retina. I hereby authorize payment of insurance benefits directly to East Coast Retina for services rendered. I further authorize the use of disclosure of my health information for the purpose of treatment, payment, or healthcare operations. I understand that I am responsible for payment of any amounts not covered by insurance.

Signature Required_____Date_____