PATIENT REGISTRATION: *In order for HD Retina Eye Center (HD Retina) to best care for you it is necessary for you to provide the following information as completely as possible.*

REFERRED BY:

PRIMARY CARE PHYSICIAN:

Name:	**Date of Birth:** Pt#:
Address 1:	**Social Security #:**
City/State/Zip:	**Sex: Marital Status:**
Address 2 (seasonal):	
City/State/Zip:	**Employer:**
Home Phone #:	**Emergency Contact:**
Work Phone #:	**Emergency Phone #:**
Cell Phone #:	**Emergency Relationship:**

Guardian Papers:____ **Durable Power for Health Care:____** **Advanced Directives:____**
(IF YES TO ABOVE QUESTIONS, PLEASE PROVIDE A COPY OF YOUR MEDICAL RECORD)

GUARANTOR INFORMATION

Name:	Date of Birth:
Address:	Social Security#:
City/State/Zip:	
	Employer:
Home Phone#:	Employer Address:
Work Phone#: Cell Phone#:	Employer City/State/Zip: ,

INSURANCE INFORMATION

Primary Carrier:	**Secondary Insurance:**
Certificate#:	Certificate #:
Group Number:	Group Number:
Group Name:	Group Name:
Copay:	Copay:
Subscriber Name:	Subscriber Name:
Subscriber Birthdate:	Subscriber Birthdate:

AUTHORIZATION FOR TREATMENT: I hereby authorize the physicians of the HD Retina Eye Center, Ltd to render medical and surgical treatment for my condition(s) as determined to be medically necessary.

ASSIGNMENT OF BENEFITS: I assign all medical and/or surgical benefits including major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to the HD Retina Eye Center, Ltd. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the release of all information to secure payment.

AUTHORIZATION TO RELEASE INFORMATION: In addition to the above authorized physicians, my condition and/or financial status may be discussed with _____ who is related to me as my _____.

AUTHORIZATION TO RELEASE INFORMATION TO OTHER THAN PHYSICIANS OR HEALTH CARE PROVIDERS: I request the HD Retina Eye Center, Ltd. to release information to our billing service for the purpose of submitting a claim for payment of services rendered.

Signed: _____ Date: _____
If a minor or guardian, state your relationship to patient: _____

I have received and read **The HD Retina Patient Confidentiality and Disclosure Statement.** I authorize HD Retina to release medical information necessary to process all claims. I also authorize the payment of any or all benefits directly to HD Retina Eye Center, Ltd.

_____ _____

Signed (patient or parent if minor) Date