

Retina Institute of the Southeast, PC
115 Dogwood Drive, Waynesboro, GA 30830
NEW PATIENT INFORMATION SHEET

Patient Name _____ Date of Birth _____

Address _____

City, State, Zip Code _____

Social Security Number _____ Gender: Male/Female

Race _____ Ethnicity: _____

Marital Status _____ Home Phone _____

Cell Phone _____ Work Phone _____

Employer _____

Employer Address _____

Email Address _____

INSURANCE

Primary Insurance _____ Policy Number _____

Secondary Insurance _____ Policy Number _____

Tertiary Insurance _____ Policy Number _____

Insurance Policy Holder's Name (If different from patient) _____

Date of Birth _____ Gender _____ Relationship to Patient _____

Address _____

EMERGENCY CONTACT

Name _____ Phone Number _____

Address _____

Relationship to the Patient _____

Referring Doctor _____

Primary Care Physician _____

Retina Institute of the Southeast, PC
115 Dogwood Drive, Waynesboro, GA 30830
Phone 706-535-RISE (7473) Fax 706-740- RISE (7473)

ASSIGNMENT OF INSURANCE BENEFITS FORM

Assignment of Benefits:

I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE OR MEDICARE BENEFITS BE MADE ON MY BEHALF TO RETINA INSTITUTE OF THE SOUTHEAST FOR ANY SERVICES FURNISHED TO ME BY THE PROVIDER/CLINIC. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE INSURANCE COMPANY OR TO CMS (CENTERS FOR MEDICARE AND MEDICAID SERVICES) AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE TO RELATED SERVICES.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services.

Coinsurance and the deductible are based upon the charge determination of the Medicare carrier. 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.

Print Name_____

Signature_____ Date _____