PATIENT INFORMATION

PLEASE PRINT CLEARLY

ACCT# _____

2 3 8 10 11 12 14 15

E W GV SG Ln CH

Name _____ Date _____
First Last

Home Address _____

City _____ State _____ Zip _____ Home Phone _____

Sex ____ Age ____ Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social Security # _____ Date of Birth _____

Referred By _____ ☐ Yellow Pages ☐ Newspaper Ad ☐ Health Fair

Employer _____ Occupation _____

Work Address _____

City _____ State _____ Zip _____ Work Phone _____ Ext. ____

Spouse's Name & Address _____ Home Phone _____

Employer _____ Occupation _____

Work Address _____

City _____ State _____ Zip _____ Work Phone _____ Ext. ____

Spouse's Social Security # _____ Date of Birth _____

PERSON TO NOTIFY IN CASE OF EMERGENCY (NOT LIVING WITH YOU)

Name _____ Relationship _____ Phone _____

Address _____ City _____ State _____ Zip _____

Primary Care Physician's Name _____

Address _____ Phone # _____

●PLEASE TURN OVER●

I WILL BE PAYING TODAY BY:
(CHECK ONE)

❒ CASH ❒ CHECK ❒ CREDIT CARD

❒ MEDICARE ❒ SILVER STATE ❒ SIERRA HEALTH

❒ PACIFICARE ❒ MEDICAID ❒ HPN

❒ OTHER INSURANCE _____

PLEASE READ CAREFULLY AND SIGN

I understand that every visit my eyes will be dilated. I understand that it is legal to drive dilated, but I may be more comfortable if I have a driver.

I understand that I am financially responsible for all charges incurred.

I request that payment of authorized insurance benefits be made to Retina Consultants of Nevada for any services furnished me.

A handling fee will be charged for personal checks returned from the bank for any reason.

This consent acknowledges and permits Retina Consultants of Nevada to use and disclose Protected Health Information (PHI) to carry out treatment, payment or healthcare operations.

_____ _____

Patient's Signature Date