Arizona Retina & Vitreous Consultants, LLC

New Patient Registration Form

Name: _____ **Date of Birth:** ___/___/___ **Gender**: M / F
(First) **(MI)** **(Last)**

Mailing Address: _____**City:** _____**State:** _____ **Zip:** _____

Primary Phone: _____ **Secondary Phone:** _____
(Cell / Home/ Other) (Cell / Home/ Other)

How would you like to receive your appointment reminders? ☐ Phone Call ☐ Text ☐ Email

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Preferred Language: _____ **Race**: ☐American Indian/Native Alaskan ☐Black/African American ☐Asian ☐Native Hawaiian/Pacific Islander ☐White ☐Other ☐Decline to Specify

Ethnicity: ☐Hispanic ☐ Not Hispanic ☐Decline to Specify

Emergency Contact: _____ **Relationship:** _____

Primary Phone: (_____) _____- _____
May we release protected health information to this individual: ☐ YES ☐ NO

Referring Physician: _____ **Phone:** _____

Primary Physician: _____ **Phone:** _____

Preferred Pharmacy: _____ **Address:** _____

Responsible Party

Relationship to Patient: _____ or please check: ☐ **Self**

Name: _____ **Date of Birth:** _____/_____/_____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Primary Phone: (_____) _____- _____

May we discuss account details with this individual: ☐ YES ☐ NO

Insurance Information (please present insurance cards to the front desk)

Relation to Subscriber: _____ or please check: ☐ **Self**

Subscriber Name: _____Birth Date: __/____/____ Subscriber SSN#: _____-_____-_____

Primary Insurance Company: _____ID #: _____Group #: _____

Secondary Insurance Company: _____ ID #: _____Group #: _____

I consent to treatment necessary for the care of the patient mentioned above. I hereby authorize the release of medical information to physicians and to my insurance companies.

_____ _____
Signature Date

Assignment of Benefits

I assign all medical/surgical benefits to Arizona Retina & Vitreous Consultants and understand that I am financially responsible for all charges whether or not they are paid by insurance. I authorize payment to be made to the provider. In the event that the payment is made to the policyholder, I agree to submit payment in full to this office immediately. If the account is not paid in full, and prior arrangements have not been made, your account(s) may be referred to a collection agency. If your account is referred to an agency, you will be responsible for all attorney's and/or collection fees.

_____ _____
Signature Date

Notice of Privacy Practice Acknowledgement

I hereby authorize the doctor to release or procure all information necessary to secure the payments of benefits, for treatment purposes, or to another health care provider or destination at my discretion. I may revoke this authorization at any time in writing, with the exception of insurance disclosures for billing purposes. I consent to communicate via electronic means for routine matters. I further agree that a photocopy of this agreement shall be as valid as the original. I certify the above information is true and correct to the best of my knowledge. I understand that HIPAA and privacy policies are available in the office by request.

_____ _____
Signature Date

Code of Conduct

Here at Arizona Retina & Vitreous Consultants, we reserve the right to discharge or turn away any patient that is being disrespectful to other patients, employees, and physicians. I have read and understand the information on this form.

_____ _____
Signature Date