Vitreo-Retinal Associates, P.C.

PATIENT INFORMATION

Dr. Mr. Mrs. Ms. Miss	Last Name	First Name	M.I.

Social Security Number	Date of Birth	Gender Male Female

Street Address

City	State	Zip

Home Phone	Work Phone	Cell Phone

E-mail Address	Employer	Occupation

Emergency Contact Name	Emergency Contact Phone

PLEASE NOTE This is for emergency contact purposes only. In order for any medical or billing information to be disclosed, you MUST list the person named above on the Health Information Release found on the 2nd page of this form.

Marital Status		Race		Ethnicity		Preferred Language	
	Single		American Indian or Alaska Native		Hispanic or Latino		English
	Married		Asian		Not Hispanic or Latino		
	Divorced		Black or African American		Decline to Answer		
	Widowed		Native Hawaiian or Other Pacific Islander				
			White				
			Other				
			Decline to Answer				

INSURANCE INFORMATION

Insurance Policy Holder Name	Relationship to Patient

Policy Holder Date of Birth	Policy Holder Social Security Number

PATIENT PHYSICIAN INFORMATION

Family Physician (PCP)	Ophthalmologist (eyes)	Optometrist (glasses)
First & Last Name	First & Last Name	First & Last Name
Address	Address	Address
Phone	Phone	Phone

Referred to VRA by: Dr.	Phone

PATIENT AUTHORIZATION

I authorize my insurance benefits to be paid directly to VRA,
and I authorize the release of pertinent medical information to insurance carriers.

Patient Signature:	Date:

Vitreo-Retinal Associates, P.C.

Patient Name

I authorize the release of health information including but not limited to diagnosis, treatment, and financial accounting to the person(s) listed below. I understand I can revoke this authorization in writing at any time by sending a written request to VRA except to the extent that action has been taken in reliance of this authorization. I understand that information released pursuant to this authorization potentially could be subject to disclosure by the recipient, and if disclosed the information would no longer be protected by federal privacy rules. We will confer with your referring physician, primary care physician, and insurance carrier unless instructed otherwise.

I authorize the release of health information to the following person(s) and have listed their name and phone number below.

Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone
Name	Relationship to Patient	Phone

PATIENT AUTHORIZATION	
Patient Signature:	**Date:**