RETINA SERVICES OF ILLINOIS, LLC

PATIENT REGISTRATION FORM

PRIMARY OFFICE: ☐ HIGHLAND PARK ☐ RESURRECTION ☐ LAKE ZURICH

PATIENT INFORMATION			
Patient's Last Name:	**First:** Middle:	☐ Dr. ☐ Mr. ☐ Ms. ☐ Mrs. ☐ Miss	**Gender:** ☐ **Male** ☐ **Female**
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner ☐ Separated ☐ Widowed	**Age:**	**Date of Birth:**	**Home Phone:**
Street Address:	**Social Security No.:**		**Cell Phone:**
P.O. Box:	**City:**	**State:**	**Zip Code:**
Email Address:			

EMPLOYMENT INFORMATION			
Occupation: (☐ **Retired**)	Employer:	City:	Work Phone No.:

REFERRING PROVIDERS

Who is the eye doctor that referred you to us? Dr. _____ City: _____

Who is your primary physician? Dr. _____ City: _____

Do you see any specialists? Dr. _____ Specialty: _____ City: _____

Do you see any specialists? Dr. _____ Specialty: _____ City: _____

FEDERAL MEANINGFUL USE QUESTIONS	
Race (mark one):	❑ Asian ❑ Caucasian ❑ Hispanic ❑ Decline to State ❑ American Indian ❑ African-American ❑ Other
Ethnicity (mark one):	❑ Latino ❑ Not Latino ❑ Decline to State
Preferred Language (Please select one):	❑ English ❑ Spanish ❑ Cantonese ❑ German ❑ Hebrew ❑ Hindi ❑ Irish ❑ Italian ❑ Japanese ❑ Korean ❑ Mandarin ❑ Polish ❑ Russian ❑ Serbian ❑ Tagalog ❑ Other ❑ Decline to State

IN CASE OF EMERGENCY	
Name of contact:	Primary Number:
Relationship to patient:	
Name of local friend or relative *(not living at your address):*	Primary Number:

TELEPHONE AUTHORIZATION & CONTACT PREFERENCE

I, _____, give permission to Retina Services of Illinois, LLC, to leave a detailed message on my phone regarding prescription refills, test results, treatments, and financial information. Please designate which number these calls are to be received _____.

I prefer to be contacted:

❑ By telephone ❑ Through the mail

If you give your permission for the physicians and staff to speak with anyone on your behalf, you must specifically identify that person here.

Person's Name:	Relationship to Patient:

May discuss:

❑ General Information (appointment reminders) ❑ Medical Information ❑ Billing

Initial: _____

ACKNOWLEDGEMENT OF RECEIPT OF AUTHORIZATION FOR DISCLOSURE AND NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of Retina Services of Illinois, LLC, Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose a patient's confidential information.

I understand that the practice reserves the right to change the privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

Initial: _____

AUTHORIZATION FOR RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS AND FINANCIAL POLICY

I authorize Retina Services of Illinois, LLC to release to my insurance company or its representatives, any information regarding my diagnosis or records of any treatment or examination rendered to me that is required to process my claims for benefits.

I authorize and request that my insurance company pay directly to Retina Services of Illinois, LLC the amount due me in pending claims for medical treatments or Services, by reason of such treatments or Services rendered to me. This assignment will remain in effect until revoked by me in writing.

It is understood that I am directly responsible for Services rendered which are not paid by insurance. I certify that to the best of my knowledge, the information contained on this Patient Registration Form is correct.

Initial: _____

My signature acknowledges that I have read and understood the above:

Patient's Name:	**Signature:**	**Date:**