

RETINA & VITREOUS CONSULTANTS OF WI, LTD

PATIENT INFORMATION:

Last Name _____ First Name _____ Middle _____

Address _____

City _____ State _____ ZIP _____

Home Phone (_____) _____ Cell Phone: (_____) _____

Social Security # _____ - _____ - _____ Sex: ☐ Male ☐ Female Age: _____

Date of Birth: _____ E-Mail: _____

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

Race: ☐ White/Caucasian ☐ African American ☐ Other _____

Language Spoken: ☐ English ☐ Hmong ☐ Spanish ☐ Russian ☐ Other: _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic Social Security # _____ - _____ - _____

☐ Retired ☐ Employed/Employer: _____

Occupation: _____ Work Phone: (_____) _____

How would you like to be contacted: ☐ Home Phone ☐ Cell Phone ☐ Other _____

Referring

Ophthalmologist/Optomtrist: _____ Phone _____

Primary Care/

Family Doctor: _____ Phone _____

Primary Care Doctor Address: _____

Diabetic Status: ☐ Non-Diabetic ☐ Non-Insulin Dependent ☐ Insulin Dependent

WORKERS COMPENSATION INFORMATION Will this be covered under Workers

Comp Ins.? ☐ No ☐ Yes If Yes: Accident Date: _____

Company Name _____ Phone# (_____) _____

Company Address _____

City/St/Zip _____

WC Claim #: _____ Treatment Authorized by _____

EMERGENCY CONTACT INFORMATION: Please list the Nearest Friend or Relative *not* living in the same household with you:

Name _____ Phone(_____) _____
Relationship to Patient _____

RESPONSIBLE PARTY *(if different from patient):*

Last Name _____ First Name _____ Middle _____

Address _____

City _____ State _____ ZIP _____

Home Phone (_____) _____ Cell Phone: (_____) _____

PRIMARY INSURANCE INFORMATION:

Insurance Company _____

Policy Number _____

Subscriber Name _____ Sex: ☐ Male ☐ Female

Subscriber Date of Birth ____/____/____ Subscriber SS# _____

How are you related to the Policy Holder:

☐ Self ☐ Spouse ☐ Partner ☐ Mother ☐ Father ☐ Child ☐ _____

Employment Status: ☐ Retired ☐ Employed If employed please fill out below

Subscriber's Employer Name _____

Employer's Address: _____

City _____ State _____ Zip _____ Work Phone _____

Does this Policy require a Referral? ☐ Yes ☐ No ☐ Unknown

SECONDARY INSURANCE INFORMATION:

Insurance Company _____

Policy Number _____

Subscriber Name _____ Sex: ☐ Male ☐ Female

Subscriber Date of Birth ____/____/____ Subscriber SS# _____

How are you related to the Policy Holder:

☐ Self ☐ Spouse ☐ Partner ☐ Mother ☐ Father ☐ Child ☐ _____

Employment Status: ☐ Retired ☐ Employed If employed please fill out below

Subscriber's Employer Name _____

Employer's Address: _____

City _____ State _____ Zip _____ Work Phone _____

Does this Policy require a Referral? ☐ Yes ☐ No ☐ Unknown

TO OUR PATIENTS:

Retina & Vitreous Consultants of Wisconsin, Ltd., accepts assignment as participating providers in the Medicare Program. We will file claims to your primary and secondary insurance for you, if you provide us with that information. Please feel free to speak with someone in the business office if you have further questions regarding our billing practices.

PATIENT AUTHORIZATION:

1. **RELEASE OF INFORMATION:** I hereby give my consent to Retina & Vitreous Consultants of Wisconsin, Ltd., to release any information regarding my care and treatment as may be required by any insurance carrier in connection with payment by the insurance carrier of any portion of my bill.
2. **RELEASE OF MEDICAL RECORDS:** I hereby give my consent to Retina & Vitreous Consultants of Wisconsin, Ltd., to release duplicate or fax copies of medical Records regarding my care and treatment to authorized Doctors, Clinics, Myself, or Persons I Deem to receive such records. I understand this may be revoked at any time by providing my written revocation. I understand that I have the right to review Retina & Vitreous Consultants of Wisconsin, Ltd.'s **NOTICE OF PRIVACY PRACTICES**, which describes how medical information about me may be used and disclosed, and acknowledge receiving a copy of the Notice from Retina & Vitreous Consultants of Wisconsin, Ltd., with this packet unless I have received a copy of it previously.
3. **RESPONSIBILITY FOR PAYMENT / PATIENT AGREEMENT:** I understand that the physician(s) practicing under the name of Retina & Vitreous Consultants of Wisconsin, Ltd., are in no way bound by fee schedules or other guidelines published by any insurance company, government agency, etc. I agree to pay any portion of the fees charged to me that are not covered by my insurance company in the event full coverage is not afforded me or if I do not have the necessary coverage.
4. **ASSIGNMENT OF BENEFITS:** I hereby authorize payment to be rendered directly to Retina & Vitreous Consultants of Wisconsin, Ltd., for the benefits otherwise payable to me by any third party.

Patient, Guardian or POA Signature

Date

Front Desk: Please input the following:

Patient Name: _____ **Chart Number:** _____

Reviewed by: _____

RETINA & VITREOUS CONSULTANTS OF WI, LTD
Additional Release(s) of Medical Information and
Medical Records to Designated Persons.

In addition to the above consents for release of information, I authorize Retina & Vitreous Consultants of Wisconsin, Ltd., to release records and information regarding my health to the designated person(s) listed below. I understand the additional release(s) may be revoked at any time by providing my written revocation.

Person To Release to: (Name) _____

Relationship (Optional) _____ Phone Number with Area Code (Optional) _____

Type of Information to be released: (Check All That Apply)

☐ Medical History ☐ Lab Reports ☐ Surgical Reports ☐ Test Results
☐ Doctor's notes ☐ Billing/Statement Information ☐ All of the Above

This authorization expires on ____/____/____ (MM/DD/YY). If I do not indicate a date, this will expire one year from the date of my signature below.

Person To Release to: (Name) _____

Relationship (Optional) _____ Phone Number with Area Code (Optional) _____

Type of Information to be released: (Check All That Apply)

☐ Medical History ☐ Lab Reports ☐ Surgical Reports ☐ Test Results
☐ Doctor's notes ☐ Billing/Statement Information ☐ All of the Above

This authorization expires on ____/____/____ (MM/DD/YY). If I do not indicate a date, this will expire one year from the date of my signature below.

Signature of Patient, Legal Guardian or Power of Attorney _____ Date _____

You may request additional release(s) of medical information and medical 1records forms from the front desk.

Witnessed by: _____