Vitreo-Retinal Associates, P.C.

Patient Demographics Form

Dr. Mr. Mrs. Ms. Miss *(circle one)*

Last Name | First Name | Middle

- - Social Security Number

/ / Date of Birth

Male Female *(circle one)*

Single Married Divorced Widowed *(circle one)*

Home Phone | Work Phone | Cell Phone

Street Address

City | State | Zip Code

Employer | Occupation

Insurance Policy Holder Name | Relation to Patient

/ / Policy Holder Date of Birth

- - Policy Holder Social Security Number

Spouse / Guardian | Phone

Closest Relative / Friend | Phone

To enable us to communicate with your doctors, please list:

FIRST & LAST NAME:

Family Physician | **Address** | **Phone**

FIRST & LAST NAME:

Ophthalmologist (eyes) | **Address** | **Phone**

FIRST & LAST NAME:

Optometrist (glasses) | **Address** | **Phone**

Referred to VRA by: Dr. **Phone:**

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:

Vitreo-Retinal Associates, P.C.

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, address, and phone number below.

1.

Name _____ **Relationship to Patient** _____

Address _____

Phone _____

2.

Name _____ **Relationship to Patient** _____

Address _____

Phone _____

3.

Name _____ **Relationship to Patient** _____

Address _____

Phone _____

4.

Name _____ **Relationship to Patient** _____

Address _____

Phone _____

Patient Signature _____ **Date** _____