SOUTHERN VITREORETINAL ASSOCIATES, P.L.

NAME (FIRST / M.I. / LAST)		MARITAL STATUS:	
ADDRESS (STREET)		DOB (AGE)	
CITY	STATE	ZIP	SEX M ☐ F ☐
SSN#	HOME PHONE	CELL PHONE	
PLEASE CHOOSE: ETHNICITY:			
RACE: ASIAN ☐ BLACK ☐ HISPANIC ☐ INDIAN ☐ WHITE ☐ OTHER ☐			
EMAIL ADDRESS			
SPOUSE'S NAME		SPOUSE'S DOB:	
EMERGENCY CONTACT		PHONE #	

PLEASE PROVIDE RESPONSIBLE PARTY INFORMATION

NAME (FIRST / M.I / LAST)		SSN#	
ADDRESS		PHONE	
CITY	STATE	ZIP	

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHO IS YOUR PRIMARY MEDICAL DOCTOR? _____

PHARMACY NAME AND PHONE NUMBER: _____

INSURANCE INFORMATION

PRIMARY INSURANCE			
INSURED'S NAME			
RELATIONSHIP TO PATIENT		DOB	
POLICY #	GROUP #	REFERRAL #	
SECONDARY INSURANCE			
INSURED'S NAME			
RELATIONSHIP TO PATIENT		DOB	
POLICY #	GROUP #	REFERRAL #	
DATE OF INJURY	RELATED TO :	AUTO? ☐	WORK? ☐
ADJUSTER'S NAME		PHONE #	

AUTHORIZATION TO RELEASE INFORMATION

I authorize Southern Vitreoretinal Associates, P.L. and the above named doctor to release my medical records to Medicare and/or my insurance companies listed above for consideration of payment.

_____ _____

Patient's Signature **Date**

ASSIGNMENT OF BENEFITS

I request that the payment of benefits be made directly to Southern Vitreoretinal Associates, P.L. I permit a copy of this authorization/assignment of benefits to remain on file and be used in place of an original signature for claims filed and medical records released to my insurance companies. I also acknowledge that I am responsible for any charges that my insurance companies do not pay including but not limited to co-payments and deductibles.

_____ _____

Patient's Signature **Date**