Fort Lauderdale Eye Institute/Fort Lauderdale Retina Institute

PATIENT INFORMATION RECORD

(Please Print)

Patient's Legal Name: _____ Today's Date _____
First M.I. Last

Address: _____
Street City State Zip

Tel.: _____ Work Tel.: _____ Cell # _____ Email: _____

Patient's Date of Birth:_____ It is okay to confirm appt or leave message via phone _____ Sex: Male _____ Female _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced Spouse's Name _____

Pt's Social Security #: _____ Primary Language_____

Are you currently employed? ❑ Yes ❑ No ❑ Retired Primary Care Doctor _____

If Retina, who is your general eye doctor _____ Who issued insurance referral? _____

Who referred you to Ft. Lauderdale Eye Institute? _____
(Friend, relative, doctor, newspaper, phone book, insurance plan, other)

Responsible Party: _____ Telephone: ( ) _____
First M.I. Last

Patient's Employer: _____ Telephone: ( ) _____

Occupation _____ Address_____
Street City State Zip

If necessary you may discuss my medical care with: Spouse (Name) _____ Children (Name)_____

Next of Kin: _____ Relationship _____Res. Phone: ( ) _____ Work: ( )_____

I. COMPLETE IF YOU ARE A MEDICARE PATIENT

Medicare Number:_____ Is Medicare Your Primary Insurance? _____
If Medicare is not Primary, Please Complete Section II and III)

Medicare Supplemental Insurance (if any):_____

Address: _____
Street City State Zip

Group Number: _____ Policy Number:_____

II. COMPLETE IF YOU ARE NOT A MEDICARE PATIENT

Is your insurance a: PPO_____ HMO _____ Other _____

III. IS PATIENT'S CONDITION RELATED TO:

❑ Yes/❑ No...Employment (current or previous)? ❑ Yes/❑ No...Auto accident? ❑ Yes/❑ No...Other accident?

GROUP

INSURANCE COMPANY NAME: _____

Address: _____
Street City State Zip

Policy & Group Number: _____Insured SS #:_____

Name of Insured:_____Insured's Date of Birth: _____

Relationship to Patient: Self _____ Spouse _____Child _____ Student over 18 _____

Other (Please describe)_____

OFFICE POLICY REGARDING INSURANCE

We are happy to file all insurance claims for our patients. I understand that I am responsible for the payment of services rendered. I authorize any holder of medical or other information about me to be released for the purpose of billing my insurance. I understand that I am financially responsible for any co-pays, deductibles or non covered services. It is my obligation to have a referral if necessary from my primary doctor and to make sure that my doctor at FLEI/FLRI is on my insurance plan.

Signature _____Date_____