



PATIENT REGISTRATION

PATIENT INFORMATION: Mr. Mrs. Ms. Miss Dr. Race/Ethnic Group: Male Female Married Single Widowed Birthdate: / / Age:

Patient Name: FIRST MI LAST

Home Address: NO & STREET APT No CITY STATE ZIP

Home Phone: () Other Phone: () Circle: Pager Mobile Fax

Work Phone: () Ext: Employer:

Occupation: Social Security#: - -

VERY IMPORTANT: Name and phone number of nearest relative(s) and/or friend to contact in case of emergency or appointment changes:

Name: Phone: () Relation:

Name: Phone: () Relation:

Responsible Party Information (If someone other than yourself is responsible for payment):

Name: FIRST MI LAST

Home Address: NO & STREET APT No CITY STATE ZIP

Social Security#: - - Home Phone: ()

Employer: Work Phone: ()

Medical Insurance Information: (Please provide us with information on all medical/health insurance coverages that you have. We also need to make a copy of your most recent insurance card to keep on file)

Do you have TennCare? Yes No If No, have you applied for TennCare? Yes No

1) Insurance Company Name:

Address:

ID or Policy #: Group #:

Phone: () Co-Payment \$ Prior Authorization Required? Yes No

Name of Primary Insured (if other than self):

2) Insurance Company Name:

Address:

ID or Policy #: Group #:

Phone: () Co-Payment \$ Prior Authorization Required? Yes No

Name of Primary Insured (if other than self):

(Please Complete Other Side)

Name of Referring Doctor: _____

Address: _____

No & Street

City

State

ZIP

Name of Your Medical Doctor: _____

Address: _____

No & Street

City

State

ZIP

Name of Any Other Eye Doctor: _____

Address: _____

No & Street

City

State

ZIP

Signature On File Authorization

I request that payment of authorized Medicare or other Insurance payment be made to the Charles Retina Institute on my behalf for any services furnished to me by my Physician associated with the Charles Retina Institute. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agent or any carrier any information needed to determine the benefits payable for related services.

Signature of Patient or Responsible Party: _____ Date: _____

I further understand that I am responsible for the entire bill for medical services provided even though insurance has been filed on my behalf. Insurance is filed as a courtesy to our patients. Balances are due within 30 days of filing date. Insurance co-payment and/or deductible are due at the time of service. Payment for non-covered services by private insurance is also due once services are rendered.

Signature of Patient or Responsible Party: _____ Date: _____

Please COMPLETE this form and give it to the Receptionist at the Front Desk or Mail to our office:

**Charles Retina Institute, 6401 Poplar Ave., Suite 190, Memphis, TN 38119
(901) 767-4499, (800) 423-0404, Fax: (901) 761-0727**