advanced
retina & eye cancer
center

Patient name: _____ Date: _____

Date of birth: _____ SSN#: _____ Sex: M F

Address: _____ City: _____ State: ____ Zip: _____

Phone: Home: _____ Cell: _____ Preferred: ☐Home ☐Cell

Email: _____ Preferred language: _____

Race (optional): _____ Ethnicity (optional): Hispanic/Latino Y N

Emergency contact: Name: _____

Phone: _____ *Relationship:* _____

Parent/ Legal Guardian: Name: _____ DOB: _____

Address: _____ Phone: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name: _____ Location: _____

I authorize the disclosure of my personal health information to my referring physician, primary care physician, and insurance company, if applicable, via the use of written or fax transmittal, to carry out treatment, payment, or health care operations. I accept full financial responsibility for services rendered by Advanced Retina & Eye Cancer Center and agree to pay all reasonable collection costs and attorney fees in the event of default of payment on my charges. I further authorize and request insurance payments be made directly to Advanced Retina & Eye cancer Center should they elect to receive such payment. My signature below indicates that I have fully read and understand the forth written authorization.

My signature below indicates that a copy of The Privacy Policy for Advanced Retina & Eye Cancer Center has been made available to me.

Signature: _____ Date: _____