The Retina Center At Las Vegas
EXCELLENCE IN RETINA CARE

Patient Name: _____ Referred By: _____

Social Security #: _____ Birthdate: _____ Age: _____

Marital Status: __Single __Married __Divorced __Separated

Patient Address: _____ Phone: _____
City,State,Zip: _____
Employer: _____ Phone: _____
Address: _____
City,State,Zip: _____ Occupation: _____

Spouse/guarantor Name: _____ Social Security #: _____
Patient Address: _____ Phone: _____
City,State,Zip: _____ Date of Birth: _____
Employer: _____ Phone: _____
Address: _____
City,State,Zip: _____ Occupation: _____

Primary Insurance: _____ Phone: _____
Insured's Name: _____ Date of Birth: _____
Policy #: _____ Group #: _____
Address: _____
Secondary Insurance: _____ Phone: _____
Insured's Name: _____ Date of Birth: _____
Policy #: _____ Group #: _____
Address: _____

Nearest Relative or Friend not living with you: _____
Phone: _____ Relationship to patient: _____

Third Party Billing

Is your injury work related	___ yes	___ no
Is your injury, due to an accident	___ yes	___ no
If your injury is MVA related, have you obtained an accident report?	___ yes	___ no

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I hereby authorize my insurance benefits to be paid directly to the facility and physician and I am financially responsible for non-covered service, deductibles, and coinsurance. I also authorize the physicians to release my information in the processing of any insurance claims. I, acknowledge and agree that I have received a copy of the RCLV Privacy Notice.

_____ _____
Patient/Guarantor Signatures Date