Retina Associates of Missouri

Jerry R. Blair, M.D., Ph.D. -- Mari Ann Keithahn, M.D.
Wayne Davis, D.O. -- Clint Kellogg, D.O.

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: First: Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Social Security Number	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home Phone: ( )	Cell Phone: ( )

P.O. box:	City:	State:	ZIP Code:

Email Address:

Occupation:	Employer:	Employer phone no.:

Ethnicity : Hispanic or Latino / Not Hispanic or Latino / Unknown / Decline to Specify

Race: White / Black or African American / American Indian or Alaska Native /

Native Hawaiian or Other Pacific Islander / Asian / Other Race / Declined to Specify

Referring Physician:	Family Physician:

RESPONSIBLE FOR ACCOUNT

Person responsible for account (if other than Patient)	Birth date: / /	Address (if different):	Home phone no.: ( )

Relationship to Patient:

Employer:	Employer address:	Employer phone no.:

INSURANCE INFORMATION

(Please give your insurance card and photo ID to the Receptionist)

Please indicate primary Insurance Carrier:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

I authorize release of any information concerning my(or my child's) health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits and to referring physicians. I also hereby authorize payment of insurance benefits directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I understand that should my account become delinquent and collective action become necessary I may be responsible for additional fees associated with collective action. I further acknowledge that I have received a copy of the Notice of Privacy Practices.

Patient/Guardian signature	*Date*

MEDICARE PATIENTS PLEASE COMPLETE THE MEDICARE AUTHORIZATION ON THE BACK

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PATIENT'S MEDICARE, MEDIGAP AND SUPPLEMENTAL AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to RETINA ASSOCIATES OF MISSOURI, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I request payment of authorized Medigap benefits be made to this provider and also authorize any holder of medical information about me to release to the above named Medigap insurer any information needed to determine benefits payable for services from this provider.

AUTHORIZATION: I hereby authorize my insurance benefits to be paid directly to RETINA ASSOCIATES OF MISSOURI, P.C. and acknowledge that I am financially responsible for any unpaid balance.

AUTHORIZATION: I authorize RETINA ASSOCIATES OF MISSOURI, P.C. to release any medical information to insurance carriers and to referring physicians concerning my health care and treatments.

Print Patient Name	Medicare Number
Patient/Guardian Signature	*Date*