MID-HUDSON RETINA CONSULTANTS, PLLC

Please Print

PATIENT NAME ____
Last First Middle

STREET ____

CITY ______________________ STATE__________ ZIP CODE__________

HOME PHONE ______________ CELL PHONE ______________JOB PHONE______________

DATE OF BIRTH ______________ SOCIAL SECURITY #______________ SEX: ☐ F ☐ M

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED

EMERGENCY CONTACT NAME ______________ EMERGENCY CONTACT PHONE______________

REFERRING PHYSICIAN ____

PRIMARY CARE PHYSICIAN____

PHARMACY NAME ______________________ PHARMACY PHONE______________

PHARMACY ADDRESS ____

OCCUPATION ______________________ EMPLOYER'S NAME______________________

EMPLOYER ADDRESS ______________________EMPLOYER PHONE______________

MEDICARE: ☐ YES ☐ NO If Yes, Number ________________________________

PRIMARY INSURANCE ____

INSURANCE COMPANY ADDRESS ____

POLICYHOLDER NAME ______________________ ADDRESS______________________

POLICYHOLDER DATE OF BIRTH ______________ POLICY NO.______________ GROUP NO.______________

PATIENT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SECONDARY INSURANCE ____

INSURANCE COMPANY ADDRESS ____

POLICYHOLDER NAME ______________________ ADDRESS______________________

POLICYHOLDER DATE OF BIRTH ______________ POLICY NO.______________ GROUP NO.______________

PATIENT RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

I WILL BE PAYING TODAY BY: ☐ CASH ☐ CHECK ☐ CREDIT CARD

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carriers, or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the provider of service and (or) supplier for any services furnished to me by the provider of service and (or) supplier. I authorize any holder of Medicare information about me to release to my Medigap insurance, ________________________________,any information needed to determine these benefits payable for related services. HIC#______________________

SIGNED: ______________________________ DATE: ______________ HCSS06072011

If your injury is due to an automobile accident or accident on the job, please complete the information on the reverse side of this form.

NO FAULT INFORMATION - PLEASE FILL THIS OUT IF YOU WERE INJURED IN A CAR ACCIDENT

INSURANCE COMPANY:______________________________

INSURANCE COMPANY ADDRESS:______________________________ TELEPHONE #:______________

______________________________ FILE #:______________

CITY STATE ZIP

DATE OF ACCIDENT:______________ POLICY OR CLAIM #:______________

NAME OF INSURED (IF OTHER THAN CLAIMANT):______________________________

ADDRESS OF INSURED:______________________________ DATE LAST WORKED:______________

______________________________ LOCATION OF ACCIDENT:______________

CITY STATE ZIP

HISTORY OF ACCIDENT:______________________________

ATTORNEY:______________ FIRM NAME:______________

ADDRESS:______________________________ TELEPHONE #:______________

____

CITY STATE ZIP

IN CONSIDERATION OF SERVICES RENDERED TO THE ME, I HEREBY AUTHORIZE PAYMENT DIRECTLY TO MID-HUDSON RETINA CONSULTANTS, PLLC., OF ANY AND ALL FIRST PARTY NO-FAULT AUTOMOBILE INSURANCE BENEFITS TO WHICH I MAY OTHERWISE BE ENTITLED FOR SERVICES RENDERED BY THE PROVIDER, BUT NOT TO EXCEED THE PROVIDER'S REGULAR CHARGES FOR SUCH SERVICES.

IN THE EVENT THE PROVIDER'S CHARGES ARE OUTSTANDING AND I FAIL TO FILE AN APPLICATION FOR BENEFITS UNDER THE NEW YORK STATE NO-FAULT INSURANCE LAW, I HEREBY AUTHORIZE THE PROVIDER TO FILE SUCH CLAIM IN MY BEHALF SO THAT THE PROVIDER MAY REALIZE PAYMENT OF ITS CHARGES. I UNDERSTAND THAT, IF THE PROVIDER DOES NOT RECEIVE PAYMENT FROM THE INSURER, I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF THE PROVIDER'S CHARGES.

SIGNED:______________________________

I HEREBY AUTHORIZE MID-HUDSON RETINA CONSULTANTS, PLLC TO RELEASE MEDICAL INFORMATION ON MY INJURY TO THE NO FAULT CARRIER: ______________________________.

SIGNED:______________________________

WORKER'S COMPENSATION INFORMATION ONLY

WORKER'S COMPENSATION INSURANCE CARRIER: ______________________________

ADDRESS OF CARRIER:______________________________ TELEPHONE #:______________

____

CITY STATE ZIP

DATE OF INJURY:___/___/___ LOCATION: ______________________________

WCB CASE #:______________ POLICY OR CLAIM #: ______________

HOW WERE YOU INJURED? ______________________________

DATE LAST WORKED:__/__/__

ATTORNEY:______________ FIRM NAME:______________

ADDRESS:______________________________ TELEPHONE #:______________

____

CITY STATE ZIP

I HEREBY AUTHORIZE MID-HUDSON RETINA CONSULTANTS, PLLC TO RELEASE MEDICAL INFORMATION ON MY INJURY TO THE WORKERS COMPENSATION INSURANCE CARRIER ______________________________.

SIGNED: ______________________________

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKER'S COMPENSATION FOR THIS ILLNESS OR CONDITION OR IT IS DETERMINED BY THE WORKER'S COMPENSATION BOARD THAT THE ILLNESS OR CONDITION IS NOT A RESULT OF A COMPENSABLE WORKER'S COMPENSATION CASE, I, ______________ ______________, HEREBY AGREE TO PAY MID-HUDSON RETINA CONSULTANTS, PLLC THEIR USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED CASE.

DATE: ______________ SIGNED: ______________________________