MANDELL RETINA CENTER PC

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your health.

PATIENT INFORMATION

Patients Full Name	**Ethnicity** (Circle): Hispanic or Latino, Non-Hispanic or Latino, Other
Street Address	
City **State** **Zip Code**	**Language** (Circle): English, French, German, Spanish, Vietnamese, Italian, Mandarin
Home Phone **Cell Phone**	**Race** (Circle): Caucasian, African American, Hispanic, Asian, Native American, American Indian, or Alaska Native

☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated**

Soc Sec No	**Date of Birth**	**Age**	**Sex**

Employer	**Address**	**City, State, Zip Code**
Work Phone	**Occupation**	**Job Title**

SPOUSE INFORMATION

Spouse Name	**Employer**
Spouse SS#	**Address:**
	Phone#:

EMERGENCY CONTACT

Name	**Relationship**	**Phone**

Referring Physician: **Phone#:**	**Medical Doctor:** **Address:** **Phone#:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Group#:	**Group#:**
ID#:	**ID#:**

ASSIGNMENT RELEASE

I hereby authorize the release of medical information to my insurance company and agree that insurance benefits are to be paid directly to the physician. I understand that my insurance is a contract between me and the insurance company and that any filing on my behalf by the practice is done as a courtesy I request that payment under Medicare Insurance Program be made on my behalf to Dr. Barry Mandell for any services furnished by that physician. I am financially responsible for all services. I agree to pay for all costs of collection, including an attorney's fee of 33 1/3% of the balance referred to the attorney in the event of default.

Signature of Patient or Responsible Party ____________ **Date** ____________

Print Name ____________

FOR OFFICE USE ONLY
APPLY ALLERGY
LABEL HERE