RETINA GROUP
OF NEW YORK

Responsible Party Information (Insurance Holder)

Last Name: _____ MI: _____ First Name: _____

Street Address: _____ City: _____ State: _____ Zip:_____

Home Phone #:_____ Cell #: _____ Work #: _____

Date of Birth: _____ Social Security #:_____ Sex: **M** or **F**

Ethnicity: _____ Primary Language: _____

Employer: _____ Employer Address: _____

Your/Caregiver E-Mail Address: _____ Emergency Contact #:_____

Is the Patient residing in a Nursing Home/ Assisted Living/ Rehab? Y or N If Yes, Name &Address:

_____

Dependent Information (If Insurance Holder is NOT the Patient)

Last Name: _____ MI: _____ First Name: _____

Date of Birth: _____ Social Security #: _____ Sex: **M** or **F**

Home Phone #: _____ Cell #: _____ Work #: _____

Insurance Information

Primary Insurance Name: _____ Member I.D. #: _____

Secondary Insurance Name: _____ Member I.D. #: _____

PAYMENT OF BENEFITS: I authorize payment of benefits, as determined by the company, directly to James M. Maisel, M.D. **Y** or **N**

I understand that unless I have checked "YES" above, benefit payments will be paid to me. I also understand that even if I have checked "YES" above, as the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.

X_____ Date: _____

MEDICAL RELEASE AUTHORIZATION (Dependent must also sign if not minor)

I authorize any insurance company, organization, employer, hospital, physician, dentist or pharmacist to release any information requested with regard to processing my claim or medical care. I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

X_____ Date: _____

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