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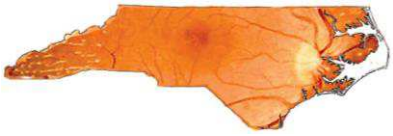
CHART #_____



RETINA INSTITUTE OF NORTH CAROLINA, PC

PATIENT DATA SUMMARY

PATIENT LEGAL NAME _____ DATE _____

SOCIAL SECURITY NUMBER _____ Marital Status **S M D W**

DATE OF BIRTH _____ Gender **M** or **F**

HOME ADDRESS _____ HOME TELEPHONE (_____)_____

CITY _____ STATE _____ ZIP _____ CELL PHONE (_____)_____

OCCUPATION _____ EMPLOYER _____

WORK ADDRESS _____ WORK TELEPHONE (_____)_____

CITY _____ STATE _____ ZIP _____

Who referred you to our office? _____

PRIMARY CARE PHYSICIAN CONTACT INFORMATION:

PRIMARY CARE PHYSICIAN **(PCP)** _____ NAME OF FACILITY _____

PCP ADDRESS _____ TELEPHONE NUMBER _____

INFORMATION OF THE PERSON RESPONSIBLE FOR THE COVERAGE:

Policy Holder's Name _____ **Effective Date _____**

RELATIONSHIP TO PATIENT _____ POLICY HOLDER'S DOB _____

HOME ADDRESS _____ HOME TELEPHONE _____

CITY _____ STATE _____ ZIP _____ WORK TELEPHONE _____

PLEASE PROVIDE THE RECEPTIONIST WITH YOUR MOST CURRENT INSURANCE CARD(S) & PHOTO ID.

EMERGENCY CONTACT: _____ **Relationship to patient: _____**

HOME ADDRESS _____ HOME TELEPHONE _____

CITY _____ STATE _____ ZIP _____ CELL PHONE _____

Authorization: I authorize Retina Institute of North Carolina, PC to furnish information to my insurance carrier(s) concerning this service. I irrevocably assign to the Retina Institute of North Carolina all payments for medical service rendered. I understand that I am financially responsible for all charges regardless of whether they are covered by my insurance carrier(s). I will pay for office visit charges at the time of service. Section 1862 (A)(1) of the Medicare law limits payment of benefits in only those services that are "reasonable and necessary." If Medicare finds that any particular service is not reasonable and necessary, even though it would otherwise be covered, it will deny payment for that service.

Signature of Responsible Party: _____ Date: _____