SOUTH CAROLINA
RETINA INSTITUTE

1404 MAIN STREET • CONWAY, SC 29526 | TEL: (843)488-1100 FAX: (843)488-7701
9400 FRONTAGE ROAD • MURRELLS INLET, SC 29576 | TEL: (843)650-0425 FAX: (843)654-1744
SOUTHCAROLINARETINA.COM

PATIENT REGISTRATION

Referred by: _____ Family Doctor: _____

Patient Name: _____ Today's Date: _____
Last First Middle

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Marital Status: Single / Married / Divorced / Widowed

Join Our Email Newsletter: ◯ Sure, Sign Me Up! ◯ No thanks.
Subscribe to our email Newsletter to receive an occasional email from us with important and useful information.

Social Security Number: _____ Date of Birth: _____ Gender: M F

Employer/Parent's Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

City: _____ State: _____ Zip Code: _____

Spouse's Name (Parent's Name if a minor): _____

Spouse's/Parent's Employer: _____

Phone: _____

Person to notify in case of emergency (other than spouse): _____

Phone: _____ Relationship: _____

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PRIMARY INSURANCE COMPANY

ID#	**Group #**	**Effective Date**
Subscriber Name		**Relationship to Patient**
Social Security Number	**Date of Birth**	**Employer**

SECONDARY INSURANCE COMPANY

ID#	**Group #**	**Effective Date**
Subscriber Name		**Relationship to Patient**
Social Security Number	**Date of Birth**	**Employer**

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly South Carolina Retina Institute to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare, the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance, and uncovered charges that may apply.

_____ _____
Patient **Today's Date**

PHARMACY INFORMATION

_____ _____ _____ _____ (____) _____
Preferred Pharmacy Street Address City State Phone Number

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southcarolinaretina.com

Physician Information

_____	_____	_____	_____	(_____) _____
Primary Care Physician	Street Address	City	State	Phone Number
_____	_____	_____	_____	(_____) _____
Other Physician's Name & Specialty	Street Address	City	State	Phone Number
_____	_____	_____	_____	(_____) _____
Other Physician's Name & Specialty	Street Address	City	State	Phone Number

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff of South Carolina Retina Institute to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access (e.g., your spouse, son, daughter, sibling, caretaker, friend):

Name of Person or Entity: _____ Relationship: _____

Name of Person or Entity: _____ Relationship: _____

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and I understand and consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

_____
Signature of the Patient or Patient Representative

I have been provided a copy of the Financial Policy to read. I understand that I, the patient, or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____
Signature of the Patient or Patient Representative

I authorize the release of any medical information necessary to process all claims and I authorize the release of

payment for medical benefits to: _____.