Northern California Retina---Vitreous Associates Medical Group, Inc.
Patient Registration

Last name:

First name:

Preferred name:

Middle name: Suffix:

Former last name:

Sex: ☐ Male ☐ Female

DOB:

Social Security #:

Address:

Address (continued):

Zip Code:

City:

State:

Home phone: ( ) - ☐ None

Mobile phone: ( ) - ☐ None

Work phone: ( ) - ☐ None

Email: ☐ None

Contact Preference: ☐ Home ☐ Work ☐ Mobile ☐ Mail

Language: ☐ Decline

Race: ☐ Decline

Ethnicity: ☐ Decline

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated ☐ Partner

Referring Doctor:

Primary Care Provider:

Primary Insurance:

Address (Street):

Address (City, State, Zip):

ID #:

Group #:

Subscriber Name:

Subscriber DOB:

Subscriber SSN:

Secondary Insurance:

Address (Street):

Address (City, State, Zip):

ID #:

Group #:

Subscriber Name:

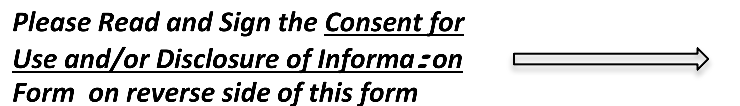
Subscriber DOB:

Subscriber SSN:

Emergency Contact:

Relationship:

Phone:



Please Read and Sign the <u>Consent for Use and/or Disclosure of Information</u> Form on reverse side of this form

Northern California Retina-Vitreous Associates Medical Group, Inc.

Consent for Use and/or Disclosure of Information:

I hereby give consent to Northern California Retina-Vitreous Associates Medical Group, Inc. to use and disclose my protected health information for the purpose of treatment, payment and health care operations. I also understand that my insurance carrier may require an authorization from my primary care physician or general ophthalmologist in order to approve this visit for payment. I understand that I will be financially responsible for all charges incurred at the time of visit should that authorization be denied. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose your protected health information. You have the right to review our Notice of Privacy Practices before you sign this consent. We reserve the right to change the terms of our Notice of Privacy Practices. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or heath care operations. We are not required to grant your request, but if we do, the restriction will be binding on us. You may revoke this consent at any time. Your revocation must be in writing, signed by you or on your behalf, and delivered to the address at the foot of this form. You may deliver your revocation by any means you choose, but it will be effective only when we actually receive it. Your revocation will not be effective to the extent that we or others have acted in reliance upon this request.

Print Name: ____ Date: ______________________

Signature: ____

If you are signing as the patient's representative:

I authorize the release of medical information on my behalf to those listed below:

Name: ___________________________________ Relationship: _________________ Initial: ________

Name: ___________________________________ Relationship: _________________ Initial: ________

You may obtain a copy of the current notice by requesting it at the time of your appointment or submitting a written request to the address below:

Northern California Retina-Vitreous Associates Medical Group, Inc.
Attention: Privacy Officer
2485 Hospital Drive, Suite 200
Mountain View, CA 94040