PACIFIC NORTHWEST RETINA

Patient Information

Name (Last)	(First)		(M.I.)
Previous Last Name	Nickname		
SSN	Birth Date	Age	Sex
Mailing address (Street)		(Apt/Unit)	
(City)	(State)	(Zip)	
Race	Primary Language	Ethnicity	
Marital Status	Do you need an interpreter? Yes / No		
Primary Care Physician		Fax #	
Referring Physician		Fax #	
Eye Doctor (or Optometrist)		Fax #	

Contact Information

Home Phone	Ok to leave a message?	☐ Yes	☐ No
Day Phone	Ok to leave a message?	☐ Yes	☐ No
Cell Phone	Ok to leave a message?	☐ Yes	☐ No
E-Mail	Ok to send a message?	☐ Yes	☐ No
Emergency Contact	Relationship		
Emergency Phone	Ok to leave a message?	☐ Yes	☐ No
Pharmacy Name		Location	
Pharmacy Fax #		Phone #	

Billing Information

Are you uninsured or self pay? ☐ No ☐ Yes, I understand that by selecting this option I am responsible for the full balance of my visit.		
Primary/Secondary Insurance:		
Does your insurance require a referral to see a specialist?	☐ Yes	☐ No

Referral Policy: I, the undersigned, realize that my insurance may require a referral/authorization before it will pay for this visit. If any referral and/or authorization is required and not received for this visit, I understand that I am responsible for the total amount of this exam.

Names of people who can have access to your records:	
Name/Relationship	Name/Relationship

Patients 18 or Over: If your insurance plan(s) will not cover all or part of the fees, or if you are Self Pay, you will be responsible for the balance.	
Minor Patients: If your insurance plan(s) will not cover all or part of the fees, or if you are Self Pay, who is responsible for the balance?	
Guarantor Name	DOB
Relationship to Patient	Phone #

I hereby assign all benefits to include major medicals benefits to which I am entitled. I hereby authorize and direct my insurance companies, including Medicare, Private Insurance, Auto, Workman's Comp and other health/medical plans to issue payments directly to Pacific Northwest Retina for medical services rendered to myself and/or my dependents regardless of my insurance benefits. I understand I am responsible for any amount not covered by my insurance company to include Copay, Coinsurance, Deductible or other Non-Covered Services.

Signature of Patient, Patient's Guardian or Patient Representative Date