

FOR OFFICE USE ONLY

Date _____ Ref MD: _____, ___ 1 mult Location _____ Phone _____
 _____ Ref MD: _____, ___ 1 mult Location _____ Phone _____
 => _____ Ref MD: _____, ___ 1 mult Location _____ Phone _____

| | | | | | | |
|---------------------------------|---------------------------|-----------------|---------------|---------------|----------------|-------------|
| •PATIENT LAST NAME | •FIRST | •M.I. | •AGE | •SEX | •DATE OF BIRTH | •OCCUPATION |
| •ADDRESS | •CITY | •STATE | •ZIP | •HOME PHONE # | | |
| •EMPLOYED BY | •ADDRESS | •CITY & STATE | •ZIP | •WORK PHONE # | | |
| •SOCIAL SECURITY # | •DRIVERS LICENSE # (copy) | •MARITAL STATUS | | | | |
| •SPOUSE NAME | EMPLOYED BY | •ADDRESS | •CITY & STATE | •ZIP | •PHONE NUMBER | |
| •EMERGENCY CONTACT (NOT SPOUSE) | •RELATIONSHIP | •PHONE NUMBER | | | | |

INSURANCE INFORMATION-----

| | | | | |
|------------------------------|--------------------|-------|----------------|--------|
| • <u>PRIMARY</u> INSURANCE | •INSURANCE ADDRESS | •CITY | •STATE | •ZIP |
| •SUBSCRIBER NAME | •I.D. NUMBER | •SEX | •DATE OF BIRTH | •PHONE |
| • <u>SECONDARY</u> INSURANCE | •INSURANCE ADDRESS | •CITY | •STATE | •ZIP |
| •SUBSCRIBER NAME | •I.D. NUMBER | •SEX | •DATE OF BIRTH | •PHONE |

DO YOU HAVE A CO-PAY ? _____ AMOUNT _____

HAVE YOU BEEN TO ANY OF OUR OFFICES BEFORE FOR ANY REASON? YES NO

TREATMENT/PAYMENT AUTHORIZATION to Orange County Retina (Dr. Maggiano, Dr. Chen Dr. You)

Permission is granted for examination, diagnosis, and treatment for any medical condition I may have. I hereby authorize Orange Co. Retina to furnish information to my insurance carriers concerning this medical condition, illness, or accident, unless otherwise noted. Permission is also given to release information to other physicians as necessary, for the treatment of my medical conditions. I hereby irrevocably assign to the doctor all payments for medical services rendered, if I have not paid in full at the time of service. As a courtesy to me, I understand my Insurance company will be billed for medical services, and I further understand that insurance billing does not guarantee payment to the doctor. I understand the doctor will refund overpayment amounts, if any. **I understand that I am financially responsible for all incurred charges, whether or not covered by insurance.** I agree that in the event of default in any amount due, to pay any additional charges equal to the cost of collection, including agency and/or attorney fees and/or court costs incurred, as permitted by the laws governing these transactions. Noted Exceptions _____

•SIGNATURE _____ •DATE _____

===== **FOR OFFICE USE ONLY:** Change this sheet if Ins Category changes. Put under new Reg sheet. **STAFF INITIALS** _____

Reg sheet ≤ 3 mo? Ref MD location, phone phone # verified? DL copy? All Bullets filled-in?
 Ins Card copy? Coverage Verified? Author necessary? [yes no] copay-deduct collected? [yes envelope]

CIRCLE ONE: CSH P WC MON HMO PPO IPA ECA POS MC MM CalOpt CCS

| | | | | |
|------------------|--------------|-----------------|----------------|------------|
| VISIT DATE _____ | CAP ? YES NO | AUTH. FOR _____ | VERIFIED _____ | DATE _____ |
| VISIT DATE _____ | CAP ? YES NO | AUTH. FOR _____ | VERIFIED _____ | DATE _____ |
| VISIT DATE _____ | CAP ? YES NO | AUTH. FOR _____ | VERIFIED _____ | DATE _____ |

Insurance category definitions:

| | |
|--------|-----------------------------------|
| CSH | cash |
| P | private |
| WC | workman's comp |
| FHP | family health plan |
| MON | monarch |
| HMO | health maintenance organization |
| PPO | preferred provider organization |
| IPA | independent physician association |
| ECA | Eye Care Affiliates |
| POS | point of service |
| MC | medicare |
| MM | medicare/medi-cal |
| CalOpt | CalOptima |
| MSI | medical services for the indigent |
| CCS | california children services |