RETINAL EYE CARE ASSOCIATES

PETER J. LOWE, M.D., P.A

RETINA – VITREOUS – MACULA CONSULTANTS OF PALM BEACH COUNTY

PATIENT INFORMATION:

NAME:_____DOB:_____SSN:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____CELL:_____EMAIL:_____

ETHNICITY: WHITE / AFRICAN AMERICAN / HISPANIC /
OTHER_____

SINGLE / MARRIED / DIVORCED / WIDOWED / OTHER **GENDER**: MALE / FEMALE / OTHER

PREFERRED LANGUAGE: ENGLISH / SPANISH /
OTHER_____

EMPLOYER:_____WORK PHONE:_____

SPOUSE NAME:_____SPOUSE DOB:_____

REFERRING PHYSICIAN:_____PHONE:_____

PRIMARY CARE PHYSICIAN_____PHONE:_____

PHARMACY/LOCATION/PHONE #_____

ALTERNATE ADDRESS AND PHONE NUMBER FOR SEASONAL RESIDENTS

ADDRESS:_____CITY:_____STATE:___ZIP:_____PHONE:_____

EMERGENCY CONTACT NAME/PHONE/RELATIONSHIP:_____

INSURANCE/POLICY HOLDER INFORMATION:

PRIMARY INSURANCE:_____EFFECTIVE DATE:_____PHONE:_____

POLICY HOLDER NAME:_____POLICY #_____

SECONDARY INS.:_____EFFECTIVE DATE:_____PHONE:_____

POLICY HOLDER NAME:_____POLICY #_____

IS THS WORK RELATED? YES / NO DATE OF INJURY_____

HOW DID YOU HEAR ABOUT US?_____

OVER

Insurance is a contract between you and your insurance company. In MOST cases, we are NOT a party to this contract. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual & customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

Non-Medicare Patients: I, the undersigned (patient/legal guardian) authorize medical treatment to be rendered by Peter J. Lowe, M.D., P.A., Retinal Eye Care Associates. I authorize the release of any medical information for insurance purposes.

By signing this form, I accept full responsibility for all charges not covered by my insurance (deductibles, co-payments, etc.)

DATE:_____SIGNATURE:_____

Medicare Patients: I, certify that the information given by me in applying for payment under Title XVIII and/or Title XIX of medical or other information about me to release the Social Security Administration or its intermediary carriers, any information needed for this or a related Medicare/Medicaid claim. I request that payment of authorized Medigap benefits be made on my behalf to Peter J. Lowe, M.D., P.A., Retinal Eye Care Associates for services rendered by same. I authorize any holder of medical information about me to release to _____ (name of secondary insurance company) any information needed to determine health benefits.

DATE:_____SIGNATURE:_____