Conley Corporate Center
7101 Guilford Drive, Suite 201
Frederick, MD 21704
Phone 301.662.2775
Fax 301.662.2776

GREATER POTOMAC RETINA
CHET B. PATEL, MD

Commerce Park Professional Center
20 Expedition Trail, Suite 102
Gettysburg, PA 17325
Phone 717.334.9006
Fax 717.334.9007

Patient Registration Form

Please assist us in obtaining complete information so that we may bill your insurance company for you. By law, we are required to bill Medicare directly if you have coverage. Other insurance companies will reimburse patients for office visits via their major medical plan. An insurance form can be provided upon request for billing major medical.

PERSONAL INFORMATION

Name_____
Last First Title MI *(Please use your full name, no nicknames)*
Street Address_____
City_____State_____Zip_____
Sex: □ Male □ Female Marital Status: □ Single; □ Married; □ Divorced; □ Widowed; □ Other
Social Security #_____ Date of Birth ____/_____/_____
Home Phone _____Work Phone_____ Day Phone_____
Parent/Guardian/Emergency Contact Full Name and Phone Number: _____
Employer Company
Name_____
Address_____
City_____State_____Zip_____
Referral Source: □ MD □ DO □ OD □ Other _____
Name_____
Address_____
City_____State_____Zip_____
Phone_____
Primary Care Doctor: □ MD □ DO □ Other _____
Name_____
Address_____
City_____State_____Zip_____
Phone_____

INSURANCE INFORMATION

Primary Insurance Company

_____
Identification # (please include letters and spaces)_____
Group # or Name_____ Effective Date of Coverage_____
Subscriber Name_____ Subscriber Social Security # _____
Birth date_____ Relationship: _____
Secondary Insurance Company

_____
Identification # (please include letters and spaces)_____
Group # or Name_____ Effective Date of Coverage_____
Subscriber Name_____ Subscriber Social Security # _____
Birth date_____ Relationship: _____
Other Pertinent Insurance Information_____

Insurance Authorization:

I hereby assign all medical and/or surgical benefits to which I am entitled, including Medicare, or any private health plan to Greater Potomac Retina and Chet B. Patel, MD. This assignment is considered as valid as an original. I understand that I am financially responsible for any amount not covered by insurance or any amount deemed the subscriber's responsibility as defined by my insurance company, particularly co-payments and deductibles.
Date_____Signature_____