Vitreo-Retinal Associates

Blue Sky VISION Partner

PATIENT DEMOGRAPHICS FORM

PATIENT INFORMATION			
Dr / Mr / Mrs / Ms / Miss	**Last Name**	**First Name**	**M.I.**
Social Security Number	**Date of Birth**	**Gender** M / F	
Street Address			
City	**State**	**Zip**	
Home Phone	**Work Phone**	**Cell Phone**	
Email Address	**Employer**	**Occupation**	
Emergency Contact Name*	**Emergency Contact Phone**		

*****PLEASE NOTE*** This is for emergency contact purposes only. For any medical or billing information to be disclosed, you MUST list the person named above on the Health Information Release found on Page 2 of this form.**

Marital Status		Race		Ethnicity		Preferred Language	
	Single		American Indian or Alaska Native		Hispanic or Latino		English
	Married		Asian		Not Hispanic or Latino		
	Divorced		Black or African American		Decline to Answer		
	Widowed		Native Hawaiian / Other Pacific Islander				
			White				
			Other				
			Decline to Answer				

INSURANCE INFORMATION	
Insurance Policy Holder Name	**Relationship to Patient**
Policy Holder Date of Birth	**Policy Holder Social Security Number**

PATIENT PHYSICIAN INFORMATION		
Family Physician (PCP)	**Ophthalmologist (eyes)**	**Optometrist (glasses)**
First & Last Name	**First & Last Name**	**First & Last Name**
Address	**Address**	**Address**
Phone	**Phone**	**Phone**
Referred to VRA by:		**Phone**

PATIENT AUTHORIZATION	
I authorize my insurance benefits to be paid directly to VRA, and I authorize the release of pertinent medical information to insurance carriers.	
Patient Signature	**Date**

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Patient Name

I authorize the release of health information including but not limited to diagnosis, treatment, and financial accounting to the person(s) listed below. I understand I can revoke this authorization in writing at any time by sending a written request to VRA except to the extent that action has been taken in reliance of this authorization. I understand that information released pursuant to this authorization potentially could be subject to disclosure by the recipient, and if disclosed the information would no longer be protected by federal privacy rules. We will confer with your referring physician, primary care physician, and insurance carrier unless instructed otherwise.

I authorize the release of health information to the following person(s) and have listed their name and phone number below.

Name	**Relationship to Patient**	**Phone**
Name	**Relationship to Patient**	**Phone**
Name	**Relationship to Patient**	**Phone**
Name	**Relationship to Patient**	**Phone**
Name	**Relationship to Patient**	**Phone**
Name	**Relationship to Patient**	**Phone**

PATIENT AUTHORIZATION	
Patient Signature	**Date**