Retina Associates of St. Louis

PATIENT MEDICAL INSURANCE INFORMATION

Patient Name: _____
(last) (first) (middle initial)

Birth Date: _____ Social Security Number: _____

Spouse Name: _____ Spouse Birth Date: _____

Spouse Social Security Number: _____

Patient's Employer: _____ Employer Phone: _____

Employer's Address: _____

Primary Insurance

Name of Subscriber: _____ Relationship: _____

Company: _____ Policy Number: _____

Group Number: _____ Effective Date of Insurance: _____

Secondary Insurance

Name of Subscriber: _____ Relationship: _____

Company: _____ Policy Number: _____

Group Number: _____ Effective Date of Insurance: _____

Please read and sign

I request that payment of authorized Medicare and private insurance benefits on my behalf be paid to Retina Associates of St. Louis, Inc for any service provided to me by David A. Glaser, MD, and/or Carla Territo, MD and/or B. Wayne Dudney, MD or associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event this account is not paid in a timely manner, it will be turned over to a collection agency and collection fees will be applied.

_____ _____

Patient Signature Date

Retina Associates OF ST. LOUIS

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