PATIENT REGISTRATION FORM

First Name: _________________________ Last Name: _________________________ Middle Initial: _____

Marital Status (circle one): Single Mar Div Sep Wid Title (circle one): Mr. Ms. Mrs. Dr.

Street Address: ________________________________ Apt #: ___________ City: ______________________

State: ________ Zip: ___________ Date of Birth: ____/____/______ Social Security: ______-______-______

Home #: ______________________ Cell #: ______________________ Work #: ______________________

Email: _______________________________________

(By providing my email address I am authorizing VRMNJ to use my email to communicate with me or whom I authorized by using this method)

Employment Status (circle one): Full-Time Part-Time Retired Unemployed Disabled Self-Employed

Employer: _______________________ Occupation: ________________ Employer Phone: ______________

Primary Care Physician name: ________________________________ Location: ______________________

Phone #__________________________

Referring Physician name: ____________________________________ Location: ______________________

Phone #__________________________

Emergency Contact Name: _______________________________ Phone #: __________________________

Relationship to patient (circle one): Spouse Parent Sibling Child Other

Primary Insurance Company: ___________________________________

Subscriber's name: ______________________________ Relationship to patient: _________________

Employer: _____________________________________ Employer Phone #: ________________________

Date of Birth: _____/_____/_______ Social Security: _______-_______-_______

Secondary Insurance Company: ___________________________________

Subscriber's name: ______________________________ Relationship to patient: _________________

Employer: _____________________________________ Employer Phone #: ________________________

Date of Birth: _____/_____/_______ Social Security: _______-_______-_______

Please allow us to make a copy of your insurance card(s) and photo identification.

VRMNJ | VITREOUS RETINA MACULA SPECIALISTS OF NEW JERSEY

Acknowledgement / Notice of Privacy Practices

I have received a copy of VRMNJ Dr. Vatsal Doshi / Dr. Boleslav Kotlyar
Notice of Privacy Practices effective 08/19/2019
Name: ________________________________ (Please Print)
I authorize VRM NJ to discuss my private medical information with the following people:

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We are committed to provide you with the highest level of service and quality care. If you have medical insurance , we will strive to help you receive the maximum allowable benefits, in order to achieve these goals, we need your assistance and understanding of our Financial policy. Ultimately, however any and all financial liability rests with the patient.
Our office participate with most major insurance plans. We provide medical and surgical ophthalmological-retinal care to our patients. If you have a managed care plan that requires a referral to see an specialist, you must obtain a referral in order for your visit to be covered by your medical insurance. If you don't have a valid referral and wish to be seen, you will be asked to pay for the visit prior to your examination.
On occasion our staff may be able to help you obtain a referral for your visit however we are not responsible for this.

Uniform assignment of benefits and release of information statement

I hereby assign or transfer payment benefits made to me or on my behalf to Vitreous Retina Macula Specialists of NJ for any services furnished to me by this practice. I further agree that I am responsible for payment of charges incurred by me that are outside of the scope of my insurance coverage or for which my insurance company has paid me.
I hereby authorize Vitreous Retina Macula Specialists of NJ to release information acquired during the course of my examination or treatment to my referring physician or to an appropriate insurance carrier. If a Medicare patient, I further authorize release to the Health Care Financing administration and its agents any information needed to determine benefits payable for related services.
I understand if my account becomes delinquent at any point my account will be sent to a collection agency.

Patient Guardian Signature: _____________________________Date: ___________

IMPORTANT

I authorized VRMNJ to leave messages on my home voicemail or cell phone voicemail to remind me of appointments, collect any balances or any other important communications.

Patient Guardian Signature: _____________________________Date: ___________