Retina Consultants of Nashville
Demographic Form

Dr. Marcus J. Solomon, M.D.
Dr. Jay P. Glover, M.D.
Dr. Lauren M. Wright, M.D.

Patient Information

Last Name **First Name** **Middle Initial** **Suffix**			**Social Security #**
Date Of Birth	**Sex**	**Marital Status**	**Telephone Numbers** **Cell Phone:** **Home Phone:**
Mailing Address **Apt #**			
City **State** **Zip Code**			**Email Address**

Guarantor Information (If different than Patient)

Last Name **First Name** **Middle Initial**			**Social Security #**
Mailing Address **Apt #**			**Date of Birth**
City **State** **Zip Code**			**Relationship to Patient**

Employer Information

Employer	**Occupation**	**Work Phone Number**

Emergency Contact Information

Name	**Relationship to Patient**	**Contact Phone Number**

Physician Information	Insurance Information
Referring Physician	**Primary Insurance**
Primary Care Provider	**Secondary Insurance** (If Applicable)
Pharmacy Name & Location	

Payment Terms: Payment is due on date of service unless other arrangements have been made. If we are a provider our staff will file your insurance claim. You are responsible for any unpaid balance. By signing below, you acknowledge full responsibility for all service provided to you and/or dependents, and agree to pay all expenses, including collection and attorney fees, necessary to collect your account balance in full. Your visit constitutes a credit transaction and as such we, or our agent, have permission to report any unpaid balance to the credit bureaus and may seek address and employment information as necessary to effect collection of any unpaid balance. Copays must be paid prior to exam.

Benefit Assignment for Services: I hereby request that payment of Medicare, Tenncare, Medicaid, and/or other medical insurance benefits made either to me or on my behalf be made to Retina Consultants of Nashville for services furnished to me and/or my dependents. I also authorize any holder of medical information about me to release to the Centers for Medicaid/ Medicare Services (CMS), or to my Insurer, any information needed to determine these benefits or the benefits payable for related services. I also agree to promptly notify our office of any medical insurance carrier or coverage change.

PCP APPROVAL: Any patient that requires a primary care provider (PCP) approval is responsible for obtaining their own approval. Failure to obtain your PCP approval and verification may result in direct Patient Billing

Federal Privacy Act: I have received a copy of the Notice of Privacy Policy

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Patient Signature _____ **Date**_____