NEW ENGLAND RETINA CONSULTANTS, PC

David Agahigian, MD Bradley Foster, MD Andrew Lam, MD

PATIENT INFORMATION

Name: Mr. Mrs. Ms._____

Address_____

City_____State_____Zip_____

Birth Date_____ Age_____ Sex M____ F____ Soc. Sec. #_____

Telephone (Home) _____ (CELL)_____ (WORK)_____

Referring Eye Doctor_____ Primary Care Physician_____

Person to Contact in case of emergency: Name_____

Home phone_____ (OTHER TELEPHONE) _____

LOCAL Pharmacy Name_____ (Address)_____

INSURANCE INFORMATION

Medicare #_____ _Masshealth/Medicaid #_____

Blue Shield/ Medex#_____ Policyholder_____ Date of Birth_____

General Insurance Co._____Policy #_____

Policyholder Name_____Date of Birth_____

EMPLOYMENT INFORMATION

Employer Name_____

Employer Address_____

City_____State_____Zip_____

Occupation_____

AUTHORIZATION FOR TREATMENT & PAYMENT: I hereby authorize New England Retina Consultants to provide any treatment in the course of my examination: I also authorize the release of information to the insurance company and assign insurance benefit payments directly to New England Retina Consultants. I fully understand that I am primarily and financially responsible for fees incurred by the above named patient.

Signature_____Date_____

Patient Signature or parent/guardian, if minor