RETINA & GLAUCOMA ASSOCIATES
JOHN R. NORDLUND, M.D.
Registration Form

Date:_____

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone Number: _____ SSN: _____ Sex: [ ]F [ ]M

Email:_____@_____

Employer: _____ Work Phone : _____

Emergency Contact/Phone/Relation: _____

Primary Care Physician/Phone: _____

Referring Physician/Phone: _____
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Primary Insurance: _____ Secondary Ins.: _____

Policy # : _____ Group # : _____ Phone : _____

PLEASE HAVE YOUR INSURANCE CARD AND A PHOTO ID AVAILABLE FOR OUR FRONT DESK
PATIENTS ARE RESPONSIBLE FOR PROVIDING CORRECT INSURANCE INFORMATION FOR ALL VISITS

FINANCIALLY RESPONSIBLE PARTY (if different from above):

Name : _____ Address : _____

Relationship : _____ SSN : _____ DOB : _____

PLEASE STOP at the CHECK-OUT COUNTER before leaving our office. Payment for office services is due on the day of service. As part of our service we will submit your insurance claims.
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I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY OUTSTANDING CHARGES NOT COVERED BY MY INSURANCE

*IF YOU HAVE A DILATED EXAM, YOU NEED TO BE AWARE THAT THE EFFECTS OF DILATION MAY LAST 5-6 HOURS OR LONGER. DILATION WILL MAKE YOU SENSITIVE TO SUNLIGHT AND MAY MAKE IT DIFFICULT TO FOCUS CLOSE. YOU WILL NEED SUNGLASS PROTECTION, AND IF YOU DO NOT HAVE IT, WE WILL PROVIDE IT TO YOU. IF YOU DO NOT FEEL COMFORTABLE DRIVING WHILE DILATED, YOU ARE RESPONSIBLE FOR HAVING A DRIVER. *_____*
(Initial above)

RELEASE OF INFORMATION and ASSIGNMENT OF BENEFITS DECLARATION:
I hereby authorize release of any medical information necessary to process my insurance claim and also ASSIGN to the DOCTOR all payments from MEDICARE and/or other insurance provider(s) for services rendered.
I understand and agree to the above conditions.

Signature _____ Date _____

RETINA & GLAUCOMA ASSOCIATES
JOHN R. NORDLUND, M.D.
HIPAA Authorization Form

Date:_____

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone Number: _____ SSN: _____

HIPAA PRIVACY RIGHTS AND AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION:
I have read the HIPAA rights and authorization statements and give my consent for disclosure of my medical records related to treatment. I further authorize that my medical information may be shared with those listed below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature _____ Date _____