ANGIOLETTI
RETINA

NEW PATIENT REGISTRATION FORM

First Name	MI	Last Name	Suffix	Sex: M / F
Home Address			Date of Birth	
City	State		Zip Code	
Preferred Language				
Ethnicity ☐ Hispanic Origin ☐ Not of Hispanic Origin		Race ☐ American Indian or Alaskan Native ☐ Black/African ☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Hispanic or Latino ☐ White		
Home #		Work #	Cell #	
Social Security #		Marital Status ☐ S ☐ M ☐ D ☐ W	E-mail	
Patients' Employer Name, Address / Occupation				
Emergency Contact Name		Phone #	Relationship	
Referring Physician / Group Name		Phone #	City	
Primary Care Physician		Phone #	City	
Financially responsible person (if different from patient)				
Responsible person's address			Phone #	
***Are you currently residing in a Skilled Nursing Facility or Rehabilitation Center?			Yes No	
If yes, name and address of facility			Phone #	

INSURANCE INFORMATION

Primary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Address:			
ID #:	Group #:	Effective Date:	
Secondary Insurance:	Policy Holder Name:	DOB:	Sex: M / F
Address:			
ID #:	Group #:	Effective Date:	

FINANCIAL POLICY STATEMENT

Welcome to **Angioletti Retina**. Thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company, we will accept assignment. All co-pays, co-insurance and deductibles are due and payable at time of service. Failure to provide necessary referrals or current accurate billing information will result in all charges for services the sole responsibility of the patient/responsible party. You will be responsible for any balances not covered by your insurance. A return check fee of $35.00 will be assessed if your check is returned by your bank. Our cancellation and "no show" policy is as follows: First occurrence, patient will be charged a $25.00 fee. Second occurrence, patient will be charged a $35 fee. Third occurrence, patient will be charge a $50 fee. The patient may be charged the full price of the scheduled office visit for any additional "no show" or any appointment cancellation that occurs within 24 hours of a scheduled appointment.

Patient Signature _____ Date _____

HIPAA - This office will comply with all aspects as printed in our Notice of Privacy Practice, and our privacy notice will be in compliance with all appropriate laws and regulations.

PATIENT AUTHORIZATION

I hereby authorize **Angioletti Retina** to apply for benefits on my behalf for services rendered. I request payments from Medicare, Medigap, and/or any other insurance company be made directly to **Angioletti Retina**. I certify that the information I have provided on this form is correct. I authorize the release of any necessary information for this or any related claim to the above named carrier or in case of Medicare Part B benefits.
I hereby attest that I have been given and reviewed the Notice of Privacy Practice.

Patient Signature _____ Date _____

Louis S. Angioletti, M.D., F.A.C.S.
Website: www.angiolettiretinanyc.com • Email: Lsangioletti@angiolettiretinanyc.com
55 Fifth Ave. - Suite 1801, New York, NY 10003 • Tel: 212.691.4200 • Fax: 646.809.1964