montanaretina CONSULTANTS

Patient Information

Date: _____

PATIENTS LEGAL NAME: _____

First Middle Last

ADDRESS: _____

PO Box or Street City State Zip

AGE: _____ BIRTH DATE: _____ SOCIAL SECURITY NUMBER: _____

PHONE: _____ MARITAL STATUS: _____

Home Cell Work

EMPLOYER: _____

Name Address Phone

Insurance Holder Information

Please fill out when patient is not the primary insurance holder

INSURED'S NAME: _____

First Middle Last

ADDRESS: _____

PO Box or Street City State Zip

INSURED BIRTH DATE: _____ SOCIAL SECURITY NUMBER: _____

Insurance Information

Cards requested upon check-in

PRIMARY INSURANCE: _____ POLICY NUMBER: _____

PRIMARY INSURANCE ADDRESS: _____

PO Box or Street City State Zip

SECONDARY INSURANCE NAME: _____

SECONDARY INSURANCE ADDRESS: _____

PO Box or Street City State Zip

I request that **PAYMENT** of Medicare or other Insurance benefits be made directly to Mark R. Comaratta, MD, PC. I **CONSENT** to the release of medical information to the Centers for Medicare and Medicaid Services and Insurance companies for a period of one (1) year from the date of my signature. I understand that I am responsible for any balance not covered by Insurance or Medicare. I agree to pay any reasonable collection costs and attorney fees if my account is placed in collection for non-payment.

SIGNATURE: _____