Retina of Auburn & Metro-Columbus

Ram Peddada, MD, DSc
Board Certified . Fellowship Trained

(334) 521-0041 (Auburn and Dothan)
(706) 221-9702 (Columbus)

PATIENT REGISTRATION

Referred by:_____ Primary Care Doctor:_____

Patient Name._____ Today's Date_____
Last First Middle

Home Address_____

City_____State_____ Zip Code_____

Home Phone_____Cell Phone_____

E-mail address_____ Marital Status Single Married Divorced Widowed

Social Security Number_____ Date of Birth_____ Age ____ Gender M F

Employer/Parent's Employer_____Occupation_____

Work Address_____Work Phone_____

City_____State_____Zip Code_____

Spouse name (Parent name if minor)_____Spouse/Parent Work Phone_____

Person to notify in case of emergency (other than spouse)_____

Phone number (s)_____Relationship_____

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Primary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

Secondary Insurance Company		
ID#	Group #	Effective Date
Subscriber Name		**Relationship to Patient**
Social Security Number	Date of Birth	Employer

I consent for treatment as offered by Retina of Auburn & Metro-Columbus and Dr. Ram Peddada and his staff as necessary. I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Retina of Auburn & Metro-Columbus to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection. For patients covered by Medicare the patient will be responsible for 20% of the Medicare allowable charges plus any deductibles, coinsurance and uncovered charges that apply. I acknowledge that I have received and reviewed the following: (1) Registration form (this form), (2) HIPAA form, (3) Financial policy, (4) Eye Drops Use in the clinic, and (5) Review of Care Experience Disclosure. I also acknowledge that I will follow the instructions given to me in my care by Dr. Peddada and his staff from time to time and that not following those instructions may lead to worsening of my eye condition.

_____ _____

Patient's / Authorized signature **Today's date**