CENTER FOR
RETINAL DISEASES & SURGERY, LLC
STEPHEN S. PAPPAS, JR., M.D., FACS
Continuing a tradition of excellence in personalized retinal care

FIRST NAME	MI	LAST NAME	SEX(M/F)

HOME ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	WORK PHONE	CELL PHONE	PREFERRED METHOD OF CONTACT
			oMAIL oPHONE oEMAIL

DATE OF BIRTH	AGE	SOCIAL SECURITY NUMBER	MARITAL STATUS

RACE
- o AFRICAN AMERICAN/BLACK
- o AMERICAN INDIAN OR ALASKA NATIVE
- o NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- o ASIAN
- o WHITE/CAUCASIAN
- o DECLINE TO PROVIDE

EHNICITY
- o HISPANIC
- o NON-HISPANIC/NON-LATINO
- o DECLINE TO PROVIDE

PREFERRED LANGUAGE

_____

PATIENT EMPLOYER/OCCUPATION (INDICATE IF STUDENT)	PATIENT EMAIL ADDRESS

EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

REFERRING PHYSICIAN	PHONE NUMBER

PRIMARY CARE PHYSICIAN	PHONE NUMBER

IS PATIENT RESIDING IN SKILLED NURSING FACILITY? o **YES** o **NO**

INSURANCE INFORMATION

PRIMARY INSURANCE:

CARRIER:_____ ADDRESS:_____ PHONE: _____
ID#_____GROUP#_____EFFECTIVE DATE:_____
POLICY HOLDER:_____ POLICYHOLDER SSN: _____ DOB:_____

SECONDARY INSURANCE:

CARRIER:_____ ADDRESS:_____ PHONE: _____
ID#_____GROUP#_____EFFECTIVE DATE:_____
POLICY HOLDER:_____ POLICYHOLDER SSN: _____ DOB:_____

TERTIARY INSURANCE:

CARRIER:_____ ADDRESS:_____ PHONE: _____
ID#_____GROUP#_____EFFECTIVE DATE:_____
POLICY HOLDER:_____ POLICYHOLDER SSN: _____ DOB:_____

I authorize CRDS, LLC to apply for benefits on my behalf for services rendered. I request payment from my insurance company be made directly to CRDS, LLC. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided. In the event that my bill remains unpaid, I understand that it may be sent to a collection agency, and any fees incurred by CRDS,LLC for the collection process will be my responsibility.

_____ _____
SIGNATURE OF SUBSCRIBER OR BENEFICIARY **DATE**