ROBERT A. SCHUMER, M.D., PH.D.
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Ophthalmology
Specializing in Consultation, Management, and
Surgery for Adult Glaucoma

PATIENT REGISTRATION, ASSIGNMENT OF BENEFITS, AND SIGNATURE ON FILE

First Name: _____ M.I. _____ Last Name: _____

Gender (M or F): ____ Date of Birth: _____ SSN: _____-_____-_____.

Home Phone: _____ Mobile Phone: _____

Office Phone: _____ Email: _____

Preferred method of communication (circle): email phone mail

Address: _____

City: _____ State: _____ Zip _____

This information is being requested according to federal regulation
Ethnicity (check one): Non-hispanic _____ Hispanic: _____ Other: _____

Preferred Language (circle): English Other: _____ Race(s) (optional): _____

Occupation: _____ Employer: _____

Spouse's Name: _____

Primary Insurance: _____ Secondary Insurance:_____

Pharmacy Name: _____ Pharmacy location: _____

Assignment of benefits and signature on file statement: "*I hereby authorize payment of benefits to Robert A. Schumer, M.D., Ph.D. for all services rendered. I authorize my insurance benefits to be paid directly to Robert A. Schumer, M.D., Ph.D. for any balance which I have not paid in full at the time of service. I permit a copy of this authorization to be used in place of the original. I understand that I am financially responsible to the physician for charges not covered by my health insurance. I authorize Robert A. Schumer, M.D., Ph.D. to release or disclose any information required for treatment, claim processing, or health care operations.*"

Signature: _____ Date: _____