

**THE RETINA CENTER OF MAINE**  
**Mark W. Balles, M.D**  
100 Foden Road West, South Portland, ME 04106  
207-773-3937

**PATIENT INFORMATION**

TODAY'S DATE \_\_\_\_\_

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_

Referred By \_\_\_\_\_

**Chief Complaint** \_\_\_\_\_

**HEALTH INSURANCE INFORMATION**

**PRIMARY INSURANCE**

Insurance Company Name _____ Effective Date _____ <b>If you have Medicare, are you or your spouse working ?</b> Yes _____ No _____ <b>Policy Holder Name</b> _____ Billing Address _____ Telephone _____ Policy/ID # _____ Group # _____ <b>PRIMARY CARE PHYSICIAN (PCP)</b> _____
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**SECONDARY INSURANCE**

Insurance Company Name _____ <b>Policy Holder Name</b> _____ Billing Address _____ Telephone _____ Policy/ID # _____ Group # _____
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**IF YOU HAVE AN HMO PLAN, YOU MUST HAVE A REFERRAL FROM YOUR PCP**

I hereby authorize release of information necessary to file a claim with my insurance carrier and assign benefits to the doctor indicated on the claim.

<b>Signed</b> _____ <b>Date</b> _____
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