The Retina Care Center LLC

Patient Information Form

Patient's Name: ____ Date: _______________
(First) (MI) (Last) Month/Day/Year

Date of Birth: ____/____/____ Age: ____ Social Security No.: ____________________

Sex: Male Female Marital Status: Single Married Widowed Divorced
(Circle One) (Circle One)

Home Phone:(____)________ Work Phone:(____)__________Cell Phone:(___)________

Street Address: ____

City: _________________________________ State: ________ Zip Code: _____________

Employer: ___________________________________ Occupation: __________________

Can we contact you at work? __Yes __No

Preferred Spoken Language: ___ English Other:_______________________________

Ethnicity: ____Hispanic or Latino ____ Not Hispanic or Latino

Race: ___ American Indian or Alaska Native ___Asian ___Black or African American

___Native Hawaiian or other Pacific Islander ___White or Caucasian

Spouse/Parent Name: ____

Date of Birth: _____/_____/_____ Social Security Number: ______________________

Home Phone:(____)________ Work Phone:(____)__________Cell Phone:(___)_________

Employer: _________________________ Can we contact you at work? ___Yes ___No

Emergency Contact Person: ____

Relationship: ________________________________ Phone: (______)________________

The Retina Care Center, LLC respects your right to privacy. If you would like to give your permission for Medical and/or accounting information to be discussed with a family member or friend please list their name below.
Name: ____
Relationship: ____ Date: ______________

Family Physician: ______________________________ Phone: (____)________
Address:____

Optometrist/Ophthalmologist:______________________ Phone: (____)________
Address:____

Pharmacy:_____________________________________ Phone: (____)________
Address:____

INSURANCE INFORMATION Patient: ______________________________

Primary Insurance: ____

Policy No.: ___________________________ Group No.: ___________________

Policy Holder: ____________________________ Relationship: _____________

Date of Birth: _____________ Employer: _______________________________

Secondary Insurance: ____

Policy No.: ___________________________ Group No.: ___________________

Policy Holder: ____________________________ Relationship: _____________

Date of Birth: _____________ Employer: _______________________________

I hereby authorize **The Retina Care Center, LLC** to bill my insurance company (which may include release of medical information to process the claim). I also authorize payment to be made directly to **The Retina Care Center, LLC.** I agree to pay any balances and/or charges when billed for medical services rendered and accept responsibility for any balances and/or charges, not covered by insurance or if uninsured for the patient named above. I certify that I have examined the above information and that it is true, accurate and complete to the best of my knowledge.

Signature:____ **Date:**_______________

Last Revised 05/04/2011