

**ILLINOIS RETINA ASSOCIATES, S.C. / THE RETINA CENTER**  
**Confidential Patient Registration Form**

**Personal Information:**

**Appointment Date:** \_\_\_\_\_

(Circle one)    Mr.    Mrs.    Miss    Ms.

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Home Phone ( \_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_ ) \_\_\_\_\_ Cell Phone ( \_\_\_\_ ) \_\_\_\_\_

Home Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Sex:    M ( \_\_\_\_ )    F ( \_\_\_\_ )                  Social Security Number ( \_\_\_\_\_ ) - ( \_\_\_\_ ) - ( \_\_\_\_ )

Date of Birth: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_                  Age \_\_\_\_\_

Race (Circle one):    African-American / American Indian / Arabic / Asian / Caucasian / Hispanic / Oriental / Other

Marital Status (Circle one):    Single / Married / Divorced / Widowed / Separated

Prior Name \_\_\_\_\_

**Employer Information:**

Employment Status (Circle one):    Full Time / Part Time / Unemployed / Retired / Self Employed

Patient Occupation: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Student (Circle one):**                  Full Time / Part Time

Referring Doctor	Medical Doctor
Name: _____	Name: _____
Address: _____	Address: _____
City, State & Zip _____	City, State & Zip _____
Phone: ( ____ ) _____	Phone: ( ____ ) _____

## INSURANCE INFORMATION

*The receptionist will need to obtain a copy of your insurance cards*

### **Responsible Party (Guarantor) Information: (Write "Self" if patient)**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Ext \_\_\_\_\_

Sex: M ( \_\_\_\_\_ ) F ( \_\_\_\_\_ ) Social Security Number: ( \_\_\_\_\_ ) - ( \_\_\_\_\_ ) - ( \_\_\_\_\_ )

Date of Birth: (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_ Age \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

## EMERGENCY CONTACT

### **Spousal or Other Information:**

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_

### **Friend or Relative Not Living With You:**

(Circle one) Mr. Mrs. Miss Ms.

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Relation to Patient \_\_\_\_\_

Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone ( \_\_\_\_\_ ) \_\_\_\_\_

Home Address \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_