

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 (_____) _____

Home Address _____ Apt # _____

City _____ State _____ Zip Code _____

Email Address: _____

Sex: M (___) F (___) Social Security Number (_____) - (_____) - (_____)

Date of Birth: (Month) _____ (Day) _____ (Year) _____ Age _____

Race (Circle one): Asiatic Caucasian Hispanic American Indian African-American Other

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

How did you hear about us? (Circle one): Referring Doctor Friend/Relative Internet
 Seminar Yellow Pages Health Fair
 Advertisement

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

Security Question (Optional): *You may be asked one of these questions, if calling for your records

Where did you graduate from High School? _____

What city were you born in? _____

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 _____

Employer Information:

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

Patient Occupation: _____

Employer Name: _____

Employer Address: _____

City: _____ State _____ Zip Code _____

EMERGENCY CONTACT

Spousal Information:

First Name _____ Middle _____ Last _____

Home Phone (_____) _____ Work Phone (_____) _____ Ext _____

Friend or Relative Not Living With You:

(Circle one) Mr. Mrs. Miss Ms.

First Name _____ Middle _____ Last _____

Relation to Patient _____

Home Phone (_____) _____ Work Phone (_____) _____ Ext _____

Home Address _____ Apt # _____

City _____ State _____ Zip Code _____