# 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_____