ILLINOIS RETINA ASSOCIATES, S.C. / THE RETINA CENTER

Confidential Patient Registration Form

Appointment Date:_____

Primary Information

Last Name:_____ Suffix:_____

First Name:_____ MI:_____

Date of Birth: Month_____ Day_____ Year_____

Occupation:_____

SSN:_____

Gender: M F

Preferred Language: English Spanish Polish Russian

Other:_____

Marital Status:

Married Single Divorced Widowed Separated

Contact Information

Home Phone:_____

Mobile Phone:_____

Work Phone:_____

Email:_____

Security Questions (Optional)

Where did you Graduate from High School?

_____

What city were you born in?

_____

Preferred Method of Appointment Reminder: ☐ Text ☐ Voice ☐ Email ☐ All

Address Information:

Street Address:_____ APT/Unit #: _____

City: _____ State:_____ Zip Code:_____

Race(s):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ More than One Race
- ☐ Native Hawaiian
- ☐ Pacific Islander
- ☐ White
- ☐ Declined

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Declined
- ☐ Other:_____

How did you hear about us?

- ☐ Friend/Relative
- ☐ Internet
- ☐ Referring Doctor
- ☐ Second Opinion
- ☐ Other: _____

EMERGENCY CONTACT INFORMATION

Spouse / Significant Other

Last Name:_____ Suffix:_____

First Name:_____ MI:_____

Home Phone:_____

Mobile Phone:_____

Work Phone:_____

Friend or Relative Not Living with You

Last Name:_____ Suffix:_____

First Name:_____ MI:_____

Home Phone:_____

Mobile Phone:_____

Work Phone:_____

INSURANCE INFORMATION

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

Insurance Information

Guarantor Information (Responsible Party)

Self ☐

Last Name:_____ Suffix:_____

First Name:_____ MI:_____

Date of Birth: Month_____ Day_____ Year_____

Relation to Patient:_____

SSN:_____

Employer Name:_____

Employer Address:_____

Patient Employer Information

Employment Status:

☐ Full-Time ☐ Retired

☐ Part-Time ☐ Self-Employed

☐ Unemployed

Patient Occupation:_____

Employer Name:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

MEDICAL PROVIDER INFORMATION

Referring Doctor	Primary Medical Doctor
No referring doctor ☐	No medical doctor ☐
Name:_____	Name:_____
Address:_____	Address:_____
City, State, Zip:_____	City, State, Zip:_____
Phone:_____	Phone:_____

Other Physician(s) in Your Care	
Specialty:_____	Specialty:_____
Name:_____	Name:_____
Address:_____	Address:_____
City, State, Zip:_____	City, State, Zip:_____
Phone:_____	Phone:_____

Other Physician(s) in Your Care	
Specialty:_____	Specialty:_____
Name:_____	Name:_____
Address:_____	Address:_____
City, State, Zip:_____	City, State, Zip:_____
Phone:_____	Phone:_____