# 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:_____

Relation to Patient: _____

**Friend or Relative Not Living with You**

Last Name:_____ Suffix:_____

First Name:_____ MI:_____

Home Phone:_____

Mobile Phone:_____

Work Phone:_____

Relation to Patient: _____

## 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:_____ |