RETINA HEALTH INSTITUTE S.C.

Vision Redefined

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www.retinahealthinstitute.com

PATIENT INFORMATION					
LAST NAME*		FIRST NAME*			MIDDLE INITIAL
IF MINOR, NAME OF RESPONSIBLE PARENT					
DOB*	SOCIAL SECURITY #		DRIVERS LICENSE #*		
HOME ADDRESS*					APT/SUITE #
CITY*		STATE*	ZIP*		
HOME #*	DAYTIME #		FAX #		
MOBILE #*	EMAIL ADDRESS*		☐ FEMALE* ☐ MALE*		
OCCUPATION		EMPLOYER			PHONE #
ADDRESS	CITY		STATE	ZIP	

IF APPLICABLE, NAME OF SPOUSE/DOMESTIC PARTNER		
LAST NAME	FIRST NAME	MIDDLE INITIAL

IF PATIENT IS LIVING IN A NURSING FACILITY*			
NAME OF FACILITY*			
ADDRESS*			ROOM #*
CITY*	STATE*	ZIP*	

CONTACT INFORMATION FOR RESPONSIBLE PARTY/SPOUSE/PARENT (If info same as above, leave blank)			
LAST NAME	FIRST NAME		MIDDLE INITIAL
SOCIAL SECURITY #	RELATIONSHIP TO PATIENT		
ADDRESS	CITY	ZIP	
HOME #	DAYTIME #	FAX#	
CELL #	EMAIL ADDRESS*		

PATIENT REFERRAL INFORMATION			
PATIENT REFERRED BY*			**PHONE #**
ADDRESS	**CITY**	**STATE**	**ZIP**
PRIMARY CARE PHYSICIAN*			**PHONE #**
ADDRESS	**CITY**	**STATE**	**ZIP**

EMERGENCY CONTACTS (PLEASE FILL IN TWO WITH DIFFERENT CONTACT INFORMATION)			
NAME	**RELATIONSHIP**		**PHONE #**
ADDRESS	**CITY**	**STATE**	**ZIP**
NAME	**RELATIONSHIP**		**PHONE #**
ADDRESS	**CITY**	**STATE**	**ZIP**

EDUCATION, LANGUAGE & MISCELLANEOUS	
HIGHEST LEVEL OF EDUCATION	**PREFERRED LANGUAGE**
DO YOU NEED AN INTERPRETER?	
ETHNICITY:	**RACE:**

WHO CAN WE SHARE YOUR INFORMATION WITH?

Patient: **Date:**

Patient Representative / Parent: **Date:**

For patients requiring translation or verbal reading of the document, the reader/translator may document and sign below.

Reader / Translator: **Date:**

Billing Information & Responsible Party / Insurance Information

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:

INSURANCE INFORATION		
PRIMARY INSURER*	**NAME OF INSURED***	**FROM**
INSURANCE ID# / GROUP # / OTHER INFORMATION		
SECONDARY INSURER*	**NAME OF INSURED***	**FROM**
INSURANCE ID# / GROUP # / OTHER INFORMATION		
TERTIARY INSURER*	**NAME OF INSURED***	**FROM**
INSURANCE ID# / GROUP # / OTHER INFORMATION		
PHARMACY INSURER*	**NAME OF INSURED***	**FROM**
INSURANCE ID# / BIN # / PCN # / GROUP # / OTHER INFORMATION		

Patient: **Date:**

For Office Use Only:

Physician To Be Seen: **Date:**

Account Number Assigned: **Initials:**