

**PATIENT DEMOGRAPHIC INFORMATION
RETINA ASSOCIATES, PA**

TODAY'S DATE _____

NAME:

LAST _____ **FIRST** _____ **MIDDLE** _____

SSN: _____ - _____ - _____ **SEX** M _____ F _____ **AGE** _____

(Circle one) **MR. MRS. MS. MISS. DR. FR. SR.** (other specify) _____
(Suffix) **Jr. Sr.** (other specify) _____

Date of Birth Month _____ Day _____ Year _____

Home Address _____

Zip Code _____ **City** _____ **State** _____

Home phone (____) _____ - _____ **Work phone** (____) _____ - _____

Cell phone (____) _____ - _____ **Fax** (____) _____ - _____

Email _____

Marital Status (circle one) **Single Married Divorced Widowed Other** _____

Race **Black/African American** _____ **American Indian/Alaskan Native** _____
Asian _____ **Hawaiian/Pacific Islander** _____ **White** _____ **Other Race** _____

Ethnicity **Hispanic or Latino** _____ **Not Hispanic or Latino** _____ **Unknown** _____

Preferred Language _____

Emergency Contact Name(s)

_____ **Relationship** _____ **Phone#**(____) _____ - _____

Address _____

_____ **Relationship** _____ **Phone#**(____) _____ - _____

Address _____

Is everyone listed on the previous page authorized to receive medical information on your behalf?

Yes _____ No _____ Please list any authorized persons who are not listed above.

Is everyone listed on the previous page authorized to receive billing information on your behalf? Yes _____ No _____ Please list any authorized persons who are not listed above.

Please answer all four questions below, yes or no to each question.

May we leave messages pertaining to your appointments, health or billing on your answering machine; at home? _____ on your cell? _____ at your job? _____

Are you here due to an injury? (please circle) YES NO

If yes, did it happen at work? _____ at home? _____ Auto? _____

Other (please specify) _____

Who is your referring physician?

Name _____

Address _____

City _____ State _____

Phone # (____) _____ - _____

Who is your primary care physician?

Name _____

Address _____

City _____ State _____

Phone # (____) _____ - _____

Are there other physicians? If so, please list

To avoid a delay in your care, we must have insurance cards and a picture ID at the time of service.

Primary Carrier _____ (Insurance Company)

Subscriber Name _____ DOB _____

SS# _____ -- _____ -- _____ Relationship _____

ID # _____ Group # _____

Claims Address _____

Secondary Carrier _____ (Insurance Company)

ID # _____ Group # _____

Claims Address _____

I certify that I (or my dependent) have insurance coverage as stated above and agree to have insurance payments made directly to Retina Associates, P.A. to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection.

Signature _____ Date _____