PATIENT DEMOGRAPHIC INFORMATION
RETINA ASSOCIATES, LLC

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 _____

Do you consent to being contacted by Retina Associates or on behalf of Retina Associates regarding appointments, communication from your clinic, and/or feedback about your experience?

Cell Phone (text/voice) : ____Yes ____No Email: ____Yes ____No

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_____