PENNSYLVANIA RETINA SPECIALISTS
CONFIDENTIAL PATIENT REGISTRATION FORM

Please Print and provide complete information. **Date** _____

Patient's Name:
Mr. / Ms. / Mrs. / Miss _____
Circle one **First** **MI** **Last**

Address _____
Street Address

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

Home # (_____) _____ - _____ **Cell # (_____) _____ - _____** **Work # (_____) _____ - _____**

E-mail Address _____

Social Security # _____ **Date of birth** _____ **Age** _____

The following information is collected per Federal Government regulation in the Health Information Technology Act (HITECH ACT). Your response is optional.

Ethnicity (circle): Hispanic Non-Hispanic **Preferred Language** _____

Race (circle): Asian African American Caucasian Native American Other _____

Present/Prior occupation _____ **Employer** _____

Circle the following: Single / Married / Widowed / Separated / Divorced **Male / Female**

PHARMACY_____**ADDRESS**_____**PHONE # (____) _____ - _____**

Referring Doctor	Primary Care Doctor
Name:	**Name:**
Address:	**Address:**
City, State & Zip	**City, State & Zip**
Phone: ( )	**Phone: ( )**

Emergency Contact (if we are unable to reach you) _____

Relationship of this person to you _____ **Daytime Phone # (_____)** _____

This information will be reviewed with you at each visit. We will ask you to fill out a new form every two years or if any changes occur.

OVER -->

INSURANCE INFORMATION

Primary Insurance Co. _____ **ID #** _____

Subscriber's name _____ **Group #** _____

If the subscriber is different than the patient, please fill out the following subscriber info:

Social Security # _____ **Date of birth** _____

Relationship to patient _____ **Employer** _____

Is this an HMO? _____ **Do you need a referral?** _____

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Secondary Insurance Co. _____ **ID #** _____

Subscriber's name _____ **Group #** _____

If the subscriber is different than the patient, please fill out the following subscriber info:

Social Security # _____ **Date of birth** _____

Relationship to patient _____ **Employer** _____

Is this an HMO? _____ **Do you need a referral?** _____

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Tertiary (3rd) Insurance Co. _____ **ID #** _____

Subscriber's name _____ **Group #** _____

If the subscriber is different than the patient, please fill out the following subscriber info:

Social Security # _____ **Date of birth** _____

Relationship to patient _____ **Employer** _____

Is this an HMO? _____ **Do you need a referral?** _____

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IF SEEN BY US FOR A WORKER'S COMPENSATION INJURY, HR CONTACT FOR COORDINATION OF BENEFITS:

_____

Name ***Phone#***