

**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**

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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 (3<sup>rd</sup>) 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#**