Pennsylvania Retina Specialists, PC

# CONFIDENTIAL PATIENT REGISTRATION FORM

Please Print and provide complete information. Date: _____

## PATIENT INFORMATION

Mr. / Ms. / Mrs. / Miss _____
First MI Last

Address: _____

City: _____ State: _____ Zip: _____

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

Social Security #: _____-_____-_____ Date of birth: _____/_____/_____ Age: _____

Pharmacy: _____ Location: _____Phone #: (_____) _____-_____

☐ Retired Present/Prior occupation: _____ Employer: _____

Marital Status: ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced Sex: ☐Male ☐Female

## REFERRING DOCTOR

Name: _____

Practice Name: _____

Location: _____

## PRIMARY CARE DOCTOR

Name: _____

Practice Name: _____

Location: _____

## CARDIOLOGIST

Name: _____

Practice Name: _____

Location: _____

## ENDOCRINOLOGIST

Name: _____

Practice Name: _____

Location: _____

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

☐ Decline all questions in this section

**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic Preferred Language: _____

**Race:** ☐Asian ☐African American ☐Caucasian ☐Native American ☐Other _____

*The information on this form 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 #: _____

Policy holder's name: _____ Group # _____

Is this an HMO? ☐ Yes ☐ No Do you need a referral? ☐ Yes ☐ No

If the policy holder is <u>different than the patient</u>, please fill out the following:

Social Security # _____ Date of birth _____

Relationship to patient _____ Employer _____

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

Policy holder's name: _____ Group # _____

Is this an HMO? ☐ Yes ☐ No Do you need a referral? ☐ Yes ☐ No

If the policy holder is <u>different than the patient</u>, please fill out the following:

Social Security # _____ Date of birth _____

Relationship to patient _____ Employer _____

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

Subscriber's name: _____ Group # _____