PATIENT DEMOGRAPHIC INFORMATION
RETINA ASSOCIATES, PA

TODAY'S DATE_____ SFB KCN BR OTT TOP MAN EMP KCE OMN LIB LAW SED _____

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 (_____) _____-_____

Pager phone (_____) _____-_____ Email _____

Are you employed? (circle one) Yes No Status (circle one) Full Time Part Time

If employed, what is your Job Title/Status _____

If not, are you RETIRED DISABLED UNEMPLOYED HOMEMAKER (circle one) or specify here
_____

Who is your employer? _____Phone # (____) ____-_____

Address_____

City_____State_____Zip_____

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

Student? Yes _____No _____ if yes, (please circle one) Full Time Part Time

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 above authorized to receive medical information on your behalf? Yes _____ No _____ Please list any authorized persons who are not listed above.

_____

Is everyone listed above 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?_____

by email _____ If yes, your email address _____

Is your insurance under your social security number? (please circle) YES NO

If no, is your insurance under a spouse or parent? (please circle) YES NO

If relationship to insured is not self, spouse or parent, please specify the relationship

_____

Insured's Name_____ SSN_____-____-_____

Insured's Employer_____ Phone # (_____) _____-_____

Insured's Date of Birth Month _____Day _____Year _____

Please present your insurance cards to the front desk so that we may scan them into our computer system. If you have more than one insurance company, please advise which insurance is primary and which is secondary.

If you do not have your insurance card(s) with you, please specify:

Primary Carrier_____ (Insurance Company)

ID #_____ Group #_____

Claims address_____

Secondary Carrier_____ (Insurance Company)

ID #_____ Group #_____

Claims address_____

Please note: Even though we accept your insurance, this does not mean your visit(s) will be covered at 100%. You are responsible for knowing your insurance benefits. If applicable, all deductibles, copays and coinsurance will be billed to you after your insurance companies process your claims.

Do you live in a nursing facility? _____ If yes, please complete:

Name_____

Address_____

City_____State_____Zip_____

Phone number_____ Director's Name _____

If you want your monthly statements to be mailed to an address other than the one listed as your home address, please indicate here:

Name_____

Address_____

Zip Code_____City_____State_____

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 may we thank for referring you to us? Doctor, Family Member, Friend

Name_____

Address_____

City_____State_____

Phone # (____) _____-_____

Who is your primary care physician?

Name _____

Address _____

City _____ State _____

Phone # (____) _____-_____

Do you see any other physicians for your eye care?

Name _____

Address _____

City _____ State _____

Phone # (____) _____-_____

Are there other physicians? If so, please list

_____

_____

Preferred Pharmacy

Name _____

Address _____

City _____ State _____

Phone # (____) _____-_____