THE RETINA PARTNERS

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PATIENT ACCOUNT #	DATE:	DRIVERS LICENSE# (LIST STATE IF NOT CA)	SOCIAL SECURITY#
NAME (LAST, FIRST, M.I.)			
ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH (MM/DD/YY)	TELEPHONE (HOME)	TELEPHONE (MOBILE)	
EMAIL:	MARITAL STATUS __SINGLE __ MARRIED __DIVORCED __WIDOWED	GENDER ___MALE ___ FEMALE	
WHAT IS YOUR PREFERRED LANGUAGE?	RACE/ETHNICITY __BLACK/AFRICAN AMERICAN __ ASIAN __WHITE/CAUCASIAN __ MIDDLE EASTERN __ NATIVE/HAWAIIAN/PACIFIC ISLANDER __ HISPANIC/LATINO __AMERICAN INDIAN/ALASKA NATIVE __OTHER		
WHO REFERRED YOU?	YOUR EMPLOYER	TELEPHONE(WORK)	
WORK ADDRESS	CITY	STATE	ZIP CODE
SPOUSES NAME:	SPOUSE'S EMPLOYER:		
WHO DO WE CALL INCASE OF AN EMERGENCY?	RELATIONSHIP	TELEPHONE	

PRIMARY AND SECONDARY INSURANCE INFORMATION

PLEASE PROVIDE A COPY OF ALL INSURANCE CARDS AND DRIVER'S LICENSE

I hereby authorize all insurance benefits to be paid directly to THE RETINA PARTNERS. I understand that I am responsible for charges as designated by my insurance companies (e.g., deductibles, co-payments, etc.) I am also responsible for all charges not covered by insurance and for any finance fees incurred on unpaid balances. I authorize THE RETINA PARTNERS to release any information to my insurance company when requested by them.

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SIGNATURE (INSURED AND AUTHORIZED) DATE