Retina Consultants of SOUTHERN CALIFORNIA

Patient Registration Form

PATIENT INFORMATION: (Please use full legal name, no nicknames)

Last Name: _____Middle Initial: _____

First Name: _____

Address: _____

City: _____ State: _____ Zip code:_____

Home Phone #: (_____)_____ Mobile Phone # (_____)_____

Social Security #: _____ Date of Birth: _____

Email Address: _____

Sex: _____ Marital Status: _____ Race: _____Ethnicity: _____

Primary Doctor: _____Reffering Doctor: _____

EMERGENCY CONTACT:

Emergency Contact Name: _____

Emergency Phone #: (_____)_____ Relationship: _____

***** IF THE PATIENT IS A MINOR, PLEASE ADD GUARANTOR INFORMATION BELOW *****

Name: _____ Relationship to minor: _____

PRIMARY INSURANCE INFORMATION:

Insurance Name: _____

Policy ID #: _____ Group #: _____

***** IF SOMEONE OTHER THAN THE PATIENT IS THE SUBSCRIBER OF THE PLAN *****

Subscriber Name:_____

Subscriber Date of Birth: _____

Subscriber Social Security Number: _____

SECONDARY INSURANCE INFORMATION:

Insurance Name: _____

Policy ID #: _____ Group #: _____

***** IF SOMEONE OTHER THAN THE PATIENT IS THE SUBSCRIBER OF THE PLAN *****

Subscriber Name:_____

Subscriber Date of Birth: _____

Subscriber Social Security Number: _____