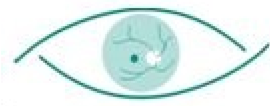

Retina Associates of South Texas

Diseases and Surgery of the Retina and Vitreous

Patient Information

Today's Date: ________________________

Patient:

Last Name: __________________________________ First Name: ______________________________________ MI: _______

Address: ____

City: ____________________________________ State: __________________ Zip code: _______________________________

SSN: _________________________ DOB: __________________ Marital Status: ( ) Single ( ) Married ( ) Other

Gender: ( ) Male ( ) Female Home Ph: _________________________ Work Ph: _______________________

Cell Ph: _________________________________ E-mail: ____

Emergency Contact:

Name: ____Ph: _____________________ Relationship: ________________

Pharmacy Information:

Name: ____ Ph: ________________________ Fax: ______________________

Employment/School Information:

( ) Employed Full Time ( ) Employed Part Time ( ) Full Time Student ( ) Part Time Student ( ) Retired ( ) Other

Occupation: __________________________________ Company/School Name: _____________________________________

Address: ____ City: __________________ State: _________ Zip: __________

Other Information: (You may decline to provide this information)

Race: _____________________________ Ethnicity: __________________________ Language: _______________________

Referring Physician Information:

Physician Name: _______________________________________ Ph: _____________________ Fax: ____________________

Insurance Information:

Who is the insured party? ( ) Self ( ) Spouse ( ) Mother ( ) Father ( ) Other _______________________

Primary Insured's Name: ______________________________________ DOB: ______________ SSN: ____________________

Secondary Insured's Name: ____________________________________ DOB:______________ SSN: ____________________

Primary Insurance Name: ______________________________ Ins. ID #: _____________________ Group #: ____________

Secondary Insurance Name: ____________________________ Ins. ID #: _____________________ Group #: ____________

Patient Signature: ____

(Parent/Legal Guardian's signature if patient is under 18 yrs)