Retina Associates of Orange County
Patient Registration Form

Patient Information

Name:_____Birthdate:_____ Male / Female *(circle one)*

Address:_____City: _____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____

Race:_____ Language: _____

Social Security #:_____ Marital Status: Married / Divorced / Widowed / Single (circle one)

E-mail Address: _____ Employer / Occupation: _____

Referring Eye Doctor:_____ Phone # _____ Fax # _____

Primary Care Physician:_____ Phone # _____ Fax # _____

Emergency Contact:_____ Phone Number:_____

Your Pharmacy Name: _____ Cross Streets: _____

Insurance Information

Primary Insurance:_____ Secondary Insurance:_____

Name of Insured:_____ Birthdate:_____

Relation to Patient:_____

Financial Responsibility

check here if patient is financially responsible_____ **<u>If not</u>, fill out below**

Name:_____ Birthdate:_____

Address:_____City: _____State:_____Zip:_____

Social Security #:_____Relationship to Patient: _____

Please Read and Sign Below

I hereby authorize the physicians and staff of Retina Associates of Orange County to perform procedures necessary to assess and diagnose my condition properly, and such treatments as may be prescribed by my attending physician during any and all visits to Retina Associates of Orange County. I understand that I am financially responsible for all charges for services rendered to me by Retina Associates of Orange County.

Signature X_____ Date _____