RETINA ASSOCIATES OF ORANGE COUNTY

Patient Registration Form

Patient Information

Name:_____ Birthdate:_____

☐ ***I'm an established patient. I acknowledge that my personal information has not changed since my last visit.***

Address:_____City: _____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____ ☐ OK to leave a detailed message

Race:_____ Language: _____ Sex:_____

Marital Status: Married / Divorced / Widowed / Single

Referring Eye Doctor:_____ Phone # _____ Fax # _____

Primary Care Physician:_____ Phone # _____ Fax # _____

Emergency Contact:_____ Phone Number:_____

Your Pharmacy Name: _____ Cross Streets: _____

Insurance Information

☐ ***I am an established patient and I acknowledge that my medical insurance has not changed since my last visit.***

Primary Insurance:_____ Secondary Insurance:_____

Name of Insured:_____ Birthdate:_____

Relation to Patient:_____

Financial Responsibility

Please Read and Sign Below

I hereby authorize the physicians and staff of Retina Associates of Orange County to perform procedures necessary to diagnose and treat 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. Also, I acknowledge that the information I provided above is true and accurate.

Name: _____

Relationship to Patient: _____

Signature : _____ Date:_____