THE RETINA INSTITUTE

Patient Registration Form

Date: ____________________

First Name: ____________________ MI: ______ Last Name: ____________________

Nickname: ____________________ Date of Birth: ____________________

SSN: ____________________ Gender: ☐ Male ☐ Female ☐ N/A

Preferred Contact No: ____________________ ☐ Cell ☐ Home ☐ Work ☐ Other

Alternative Contact No: ____________________ ☐ Cell ☐ Home ☐ Work ☐ Other

Email Address: ____________________

Mailing Address: ____________________ Apt./Suite No: __________

City: ____________________ State: __________ Zip: ____________________

Primary Care Physician: ____________________ Referring Physician: ____________________

Patient's Employer: ____________________

Pharmacy Information: ____________________

Emergency Contact: ____________________ Relation: ____________________

Emergency Contact No: ____________________ ☐ Cell ☐ Home ☐ Work ☐ Other

---

Race: ☐ White ☐ Black or African American ☐ American Indian or Alaskan Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ Decline

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Marital Status: ☐ Married ☐ Single ☐ Other

Language: ☐ English ☐ Other (Please Specify): ____________________

OFFICE USE ONLY:

Account: ____________________