Arizona Retina Associates

PATIENT INFORMATION

PLEASE **PRINT CLEARLY** AND COMPLETE ENTIRE FORM

Name _____
FIRST MIDDLE INITIAL LAST SUFFIX (Jr., etc.)

Address _____
STREET CITY STATE ZIP

Age____ Birthdate_____ SS#_____

Marital Status S M D W Sex M F

Occupation _____ Employer _____

Home phone ( ) _____ Cell phone ( ) _____

Business phone ( ) _____Ext_____ Email _____

CHECK ONE: □ Medicare/Medicaid/Insurance □ Workman's Comp □ Self-pay/no insurance

RESPONSIBLE PARTY (parent or guardian)

IF SAME AS PATIENT, THEN LEAVE THIS BLANK

Name _____
FIRST MIDDLE INITIAL LAST SUFFIX (Jr., etc.)

Relationship to Patient _____

Address _____
STREET CITY STATE ZIP

Age____ Birthdate_____ SS# _____ Sex M F

Occupation _____ Employer _____

Home phone ( ) _____ Business phone ( ) _____Ext_____

INSURANCE INFORMATION (WE MUST HAVE A COPY OF YOUR INSURANCE CARD)

Primary Company _____ Address _____

Policy Number _____ Group # _____ Phone _____

Relationship to Insured_____ Date of Birth _____

Secondary Company _____ Address _____

Policy Number _____ Group # _____ Phone _____

Relationship to Insured _____ Date of Birth _____

EMERGENCY CONTACT INFORMATION

Emergency Contact _____ Relationship _____ Phone _____