ADVANCED RETINA ASSOCIATES

WHO REFERRED YOU TO OUR PRACTICE?

____ Physician – Name _____
____ Patient – Name _____
____ Insurance Company
____ Newspaper ad- which paper _____
____ Internet

FAMILY DR _____

FAMILY DR PHONE # _____

PATIENT NAME _____

Address _____

_____
City State Zip Code

Home Phone # _____

Cell Phone # _____

Email address (optional) _____

Employer _____

Business Phone # _____

Spouse Name _____

Spouse Employer _____

Spouse Work # _____

EMERGENCY CONTACT INFORMATION:

NAME _____

RELATIONSHIP _____

PHONE #_____

TODAY'S DATE _____

SOCIAL SEC # _____

BIRTHDATE _____

INSURANCE INFORMATION

Primary Insurance Company

_____

Secondary or Supplement Insurance Company

_____

PLEASE BRING YOUR INSURANCE CARDS TO THE OFFICE

Ethnic Background –circle one

Hispanic or Latino Not Hispanic or Latino
Unknown

Race – circle one

American Indian/Alaska Native	White
Asian Indian or Other	Chinese
Black or African American	Filipino
Native Hawaiian	Pacific Islander
Guamanian	Japanese
Korean	Pacific Islander
Samoan	Vietnamese
Other	Unknown

Preferred Language _____

Smoking Status - circle one

Every day smoker Some day smoker

Former smoker Never Smoker

Smoker, current status unknown Unknown