

# PATIENT REGISTRATION

---

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Alternate Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Sex: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Marital Status: \_\_\_\_\_ Spouse Name: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Spouse Phone: \_\_\_\_\_  
Social Security No.: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Referring Doctor: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

---

## EMERGENCY CONTACT

---

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

---

## INSURANCE

---

Primary: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_  
ID/Group #: \_\_\_\_\_  
Secondary: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_  
Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_  
ID/Group #: \_\_\_\_\_

---

## ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

---

I request that payment of medical insurance benefits be made directly to Retina Associates SW, PC (RASW, PC) for services furnished to me by them. I authorize release of medical information about me to determine these benefits. It is understood that I am responsible for obtaining authorization and referrals for services per the terms of my insurance company contract. Failure to cooperate with RASW, PC in this will result in my ultimate liability for payment of my bill.

---

Signature

---

Date

---