WELCOME TO PALMETTO RETINA CENTER

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your health.

PATIENT INFORMATION	
NAME:	**DATE OF BIRTH:**
ADDRESS:	
CITY:	**STATE & ZIP CODE:**
HOME PHONE NUMBER:	**CELLULAR NUMBER:**
SOCIAL SECURITY NUMBER:	**WORK NUMBER:**
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LIFEPARTNER	**GENDER:** ☐ MALE ☐ FEMALE
RACE: ☐ WHITE ☐ AFRICAN AMERICAN ☐ HISPANIC ☐ ASIAN ☐ OTHER: _____	**ETHNICITY:** ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO
LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ OTHER: _____	**EMAIL:**

PARENT/LEGAL REPRESENTATIVE INFORMATION	
NAME:	**DATE OF BIRTH:**
ADDRESS:	
CITY:	**STATE & ZIP CODE:**
HOME PHONE NUMBER:	**CELLULAR NUMBER:**
SOCIAL SECURITY NUMBER:	**WORK NUMBER:**
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LIFEPARTNER	**RELATIONSHIP TO THE PATIENT:** ☐ PARENT ☐ SPOUSE ☐ LEGAL REPRESENTATIVE ☐ HEALTHCARE POWER OF ATTORNY ☐ OTHER

INSURANCE INFORMATION	
PRIMARY INSURANCE:	**DATE OF BIRTH OF CARDHOLDER:**
SECONDARY INSURANCE:	**DATE OF BIRTH OF CARDHOLDER:**

REFERRING PHYSICIAN INFORMATION	
REFERRING PHYSICIAN:	**PHONE NUMBER:**
PRIMARY CARE PHYSICIAN:	**PHONE NUMBER:**

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate treatment. If there is any change in my medical status, I will inform the doctor. I authorize my insurance company to pay to Palmetto Retina Center all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Failure to resolve my financial responsibilities could result in collection action and/or dismissal from the practice.

Signature:_____ **Date:** _____

REVISION DATE: 09/26/2012