RETINACENTER
OF CHICAGO

PATIENT INFORMATION SHEET

(Please Print Clearly)

Name:_____ Sex: ☐M ☐F Birthdate: ____/____/_____
Last First MI

Marital Status: ☐Married ☐Single ☐Widowed Soc. Sec. #:_____

Mailing Address: _____ Email Address: _____

City, State, Zip: _____ Primary Care Doctor: _____

Referred By: _____

Home Phone #: _____

Cell#:_____ Occupation: _____

Business Phone #: _____ Employer: _____

Responsible Party: _____ Phone#: _____

Relationship:_____

Emergency contact: _____ Phone#: _____

Relationship:_____

Primary Insurance:_____ Subscriber: _____

Subscriber No.: _____ Relationship: _____ Birthdate: _____

Medical coverage of group: _____ Employer: _____

Secondary Insurance: _____ Subscriber: _____

Subscriber No.: _____ Relationship:_____ Birthdate: _____

Medical coverage of group: _____ Employer: _____

Other Insurance: _____ Subscriber: _____

Subscriber No.: _____ Relationship: _____ Birthdate: _____

Medical coverage of group: _____ Employer: _____

I hereby authorize Retina Center of Chicago to release all medical information regarding my illness, care and/or injury to my insurance carriers, any health care facility, and any other physician that would benefit my health care. I hereby assign to Retina Center of Chicago all payment to which I am entitled for medical/surgical expenses related to the service reported from the above.

I hereby authorize Retina Center of Chicago to take photographs of my eyes for the sole purpose of research, education, and journal publication. I understand that these photographs will be anonymized and will not contain any of my personal information

I understand I am financially responsible to Retina Center of Chicago for all charges, whether or not they are paid by said insurance. A photocopy of this assignment is as valid as the original.

Date: _____ Signature: _____
(Parent or Guardian if minor)