Northern California
Retina Vitreous Associates
Established in 1983

Patient Registration Form

Last Name: ______________________________________

First Name: ______________________________________

Middle Name: ____________________ **Suffix:**_________

Former Last Name:_______________________________

Date of Birth:_______________ **Sex:** ☐ Male ☐ Female

Social Security #:_______________________________

Address:____

____

City: ____

State: ____

Zip Code: ____

Occupation: ____________________________ ☐ N/A

Employer:______________________________ ☐ N/A

Home Phone: (_______) ________ - ___________ ☐ None

Mobile Phone: (_______) ________ - ___________ ☐ None

Work Phone: (_______) ________ - ___________ ☐ None

Email:______________________________________ ☐ None

Contact Preference: ☐ Home ☐ Mobile ☐ Work ☐ Mail

Language: __________________________________ ☐ Decline

Race: ______________________________________ ☐ Decline

Ethnicity:__________________________________ ☐ Decline

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Emergency Contact: ___________________________________

Relationship: ____

Phone: ____

Preferred Pharmacy (Name/Address/City/Zip Code): ____

____

Please enter your medical insurance information below or bring your current insurance cards with you to the appointment. If you are not the plan's subscriber, please enter the name, date of birth, and social security # of the subscriber here.

Primary Insurance: _______________________________

Address:____

City, State: ____

ID #: ____

Group #:____

Subscriber Name:_____________________________________

Subscriber DOB:______________________________________

Subscriber SSN:______________________________________

Secondary Insurance: _____________________________

Address:____

City, State: ____

ID #: ____

Group #:____

Subscriber Name:_____________________________________

Subscriber DOB:______________________________________

Subscriber SSN:______________________________________

Please enter the doctor that referred you, your PCP, and any physicians who should receive a copy of your visit summary:

Referring Doctor: ____ ☐ None

Primary Care Doctor or General Physician:____ ☐ None

Any other physicians: ____