SOUTHERN CALIFORNIA DESERT RETINA CONSULTANTS
PATIENT REGISTRATION

PATIENT NAME: _____
(LAST) (FIRST) (MI)

MALE _____ **FEMALE** _____ **BIRTHDATE:** ____ / ____ / ____ **AGE:** _____

SOCIAL SECURITY #: _____ **PREFERRED LANGUAGE**_____

RACE
_____AMERICAN INDIAN OR ALASKAN NATIVE
_____ASIAN
_____BLACK OR AFRICAN AMERICAN
_____DECLINED TO SPECIFY
_____NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
_____WHITE

ETHNICITY
_____DECLINED TO SPECIFY
_____HISPANIC OR LATINO
_____NOT HISPANIC OR LATINO
_____UNKNOWN/NOT REPORTED

EMAIL: _____

PRIMARY HOME MAILING ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

HOME PHONE #: _____ **CELL PHONE:** _____

SECONDARY HOME MAILING ADDRESS (if applicable): _____

CITY: _____ **STATE:** _____ **ZIP:** _____

EMERGENCY CONTACT (RELATIVE OR FRIEND ***NOT*** LIVING WITH YOU):

_____ **PHONE #:** _____

SPOUSE or RESPONSIBLE PARTY: _____

HOME PH: _____ **CELL PH:** _____

BIRTHDATE: ____ / ____ / ____ **AGE:** _____ **SOCIAL SECURITY #:** _____

OCCUPATION: _____ **WORK PHONE#:** _____ **EXT:** _____

1ST INSURANCE CO. _____ **2ND INSURED CO.** _____

INSURED ID #: _____ **INSURED ID #:** _____

REFERRING OPHTHALMOLOGIST/OPTOMETRIST_____

PRIMARY CARE PHYSICIAN: _____

I understand that I am financially responsible for all medical bills, including all charges not covered by my insurance, deductibles, and co-pays. I certify that the foregoing is correct and true:

DATE: _____ **PATIENT / RESPONSIBLE PARTY SIGNATURE:** _____