Registration Information: Please Fill Out

Welcome to our office. We are committed to providing you with the finest, most comprehensive care possible. All information is confidential and is only released with your written consent.

Today's Date _____

Name _____ Preferred (Nickname) _____

Social Security # _____ How did you hear about us? _____

Birth Date _____ Gender _____ Marital Status _____

Address _____
Street City State Zip Code

Mailing Address _____
Street / PO Box City State Zip Code

Home Phone ( ) _____ Cell Phone ( ) _____

Appointment Reminder (Please circle) Phone Call / Text Message

Occupation / Employer _____ Business Phone ( ) _____

Ophthalmologist (Eye MD) _____ Optometrist (OD) _____

Primary Care Physician _____ Phone ( ) _____

Address _____
City State

Other Physicians _____

Preferred Language (Please circle one) English Spanish French German Italian Mandarin Vietnamese Other _____

Race (Please circle one) Caucasian Hispanic/Latino Asian Native American or Alaskan Native African American Japanese Native Hawaiian or Other Pacific Islander Undetermined Other _____

Ethnicity (Please circle one) Hispanic or Latino Non Hispanic or Latino

Primary Insurance _____

Secondary Insurance _____

Tertiary Insurance _____

Are you currently residing in a Skilled Nursing Facility ? Yes_____ No_____

Is your visit related to a **work injury**? Yes_____ No_____ Date of Injury: _____

Is your visit related to an **auto accident**? Yes_____ No_____ Date of Accident: _____

Macular Research Institute
Retina Vitreous CENTER PC