NORTH CAROLINA RETINA ASSOCIATES
Patient Registration Form

Patient Information

First Name _____ **Middle Name** _____

Last Name _____ **Date of Birth** _____

Mailing Address: Street _____

City _____ State _____ Zip _____

Phone Numbers: Cell Phone _____ Home/Evening _____

Daytime Phone *(Work / Other)* _____

Email Address _____

Social Security # _____ **Patient Employer Name** _____

(Please circle one)
Male / Female

Marital Status *(Please circle one)*
Single / Married / Divorced / Separated / Widowed

Race/Ethnic Group *(Please circle)*
American Indian / Alaska Native / Asian / Black or African American / Chinese / Filipino / Hispanic or Latino
Japanese / Korean / Native Hawaiian / Pacific Islander / Other / Unknown / White / Decline to Provide

Emergency Contact: Name _____ Number _____

Relationship to you _____

Primary Care Physician/General Practitioner _____

City / State _____ Phone Number _____

☐ Check here to receive **ELECTRONIC billing statements ONLY**. Otherwise paper bills will be sent in the mail.

Insurance Information

Primary Insurance Carrier Name _____ Policy # _____

Group # _____ *(Insurance)* Phone # _____

Secondary Insurance Carrier Name _____ Policy # _____

Group # _____ *(Insurance)* Phone # _____

Guarantor Information

☐ Check here if the **PATIENT** is financially responsible.

- If anyone **OTHER THAN THE PATIENT** is financially responsible, then please fill out the information below.

First Name _____ Middle _____ Last _____

Date of Birth _____ **Social Security #** _____

Mailing Address: Street _____

City _____ State _____ Zip _____