NORTH CAROLINA RETINA

Patient Registration Form

Patient Information

First Name _____ **Middle Name** _____ **Last Name** _____

Date of Birth _____ **Nickname** _____

Mailing Address _____ **City** _____ **State** ____ **Zip** _____

Male / Female (Please circle) **Evening** Phone # _____ **Daytime** (work) phone # _____

Mobile Phone # _____**Social Security #** _____ **Marital Status** - (Please circle)
Married / Divorced / Single / Widowed / Separated

Email address _____ **Patient Employer** _____

Emergency Contact / Relationship to you _____ **Phone #** _____

Ethnic Group : (*circle one***) Hispanic/Latino** or **Not Hispanic/Not Latino**

Primary Care Physician _____ Phone # _____

RACE:
(please circle one)

American Indian
Alaska Native
Asian
Black/African American
Chinese
Filipino
Japanese
Korean
Native Hawaiian
Pacific Islander
Other
Unknown
White

Insurance Information

Primary Insurance Carrier _____

Name of Insured (if other than patient) _____ Patient Relationship _____

Date of Birth _____

Address _____ City _____ State _____ Zip _____

Insured Phone # _____ Policy Group # _____ Policy ID # _____

Secondary Insurance Carrier_____

Name of Insured (if other than patient) _____ Patient Relationship _____

Date of Birth _____

Address _____ City _____ State _____ Zip _____

Insured Phone # _____ Policy Group # _____ Policy ID # _____

Guarantor Information

□ Check here if patient is financially responsible. If not, please provide the following information.

First Name _____ Middle Name _____ Last Name _____

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

Street Address _____ City _____ State _____ Zip _____