



# Patient Registration

New  Update

Acct: \_\_\_\_\_

Munster  Merrillville  Michigan City

### PLEASE PRINT CLEARLY

Date \_\_\_\_\_ Doctor:  Amin  Eadie  Lipman  Pelzek  Vyas

Patient Name \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Alternate # or Cell # \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Employer \_\_\_\_\_

Marital Status: PLEASE CHECK ONE  Single  Married  Divorced  Separated  Widowed

Patient Referred By \_\_\_\_\_ Address/City/Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Address/City/Phone \_\_\_\_\_

### PRIMARY INSURANCE COMPANY \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Policy # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

### SECONDARY INSURANCE COMPANY \_\_\_\_\_

Policyholder's Name \_\_\_\_\_ Policy # \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_

**NURSING HOME RESIDENT?**  YES  NO

**STATUS?**  IN-PATIENT  OUT-PATIENT

Facility Name \_\_\_\_\_ City \_\_\_\_\_

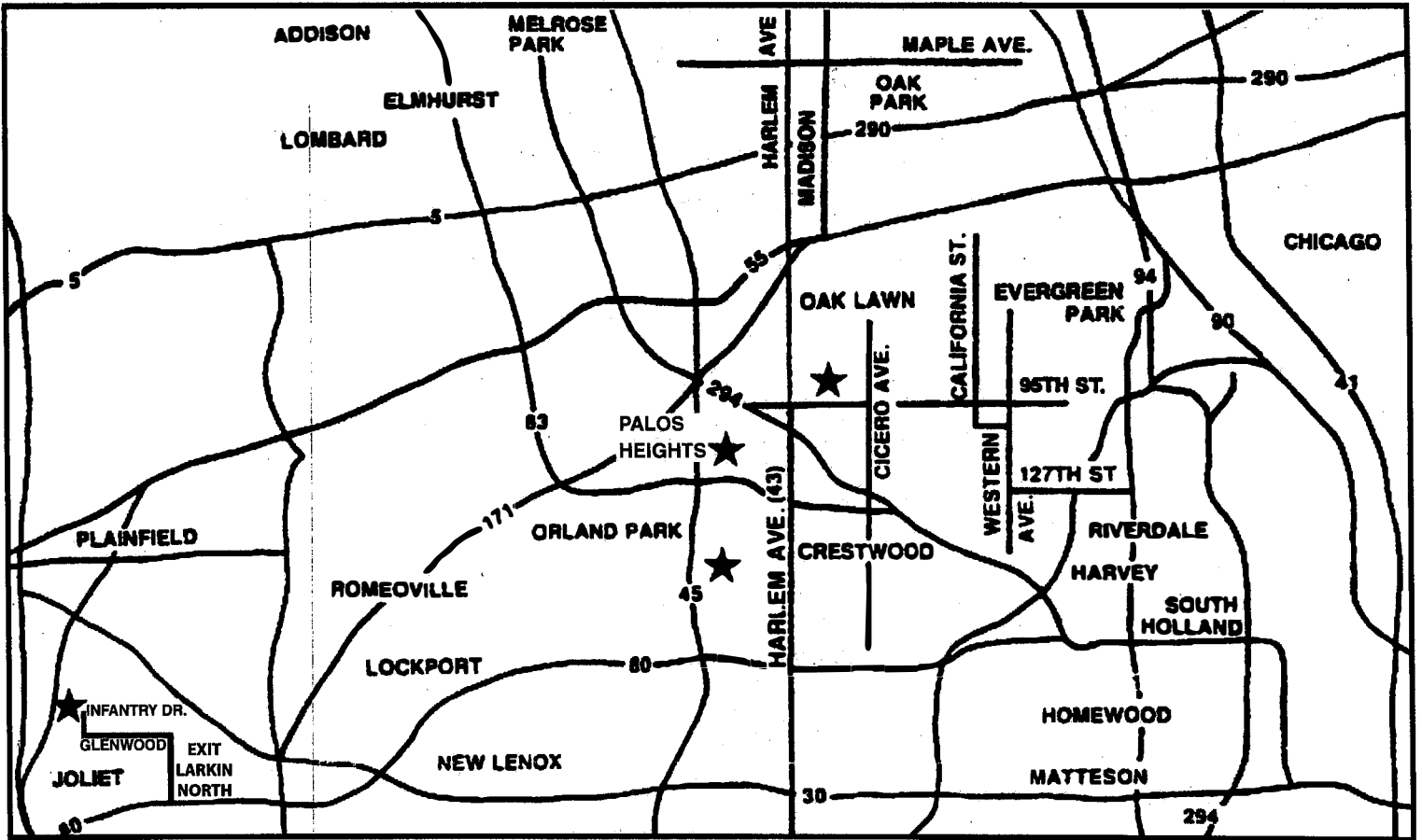
If Patient is a minor, who is responsible? \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone # \_\_\_\_\_

If accident, were you injured at:  Work  Auto  Other \_\_\_\_\_

What happened? \_\_\_\_\_ Date of Accident \_\_\_\_\_

Person to contact \_\_\_\_\_ Phone # \_\_\_\_\_



# RETINA VITREOUS ASSOCIATES

4930 West 95th Street, Oak Lawn, IL 60453

(708) 424-8855 Fax (708) 424-6954

