Oregon Retina Center

Welcome to our office. Please take your time while filling out our new patient information sheets. All information is confidential and only released with your written consent. Thank you for choosing our office to help assist you with your retinal care.

□Male □ Female Social Security Number____________________

Full Name____________________________________Date of Birth___________________

Name of Spouse______________________________Spouse Date of Birth______________

___ Married ___ Single ___Divorced ___Widowed

Residence Address ____

____

City State Zip Code

Mailing Address (If different from above)____

____

City State Zip Code

Home Phone ____________________Cell _________________Work____________________

Email ____

Emergency Contact ____

Name Telephone Number Relation

Ophthalmologist/Optometrist____

Primary Care Physician ____

Occupation-Employer_____________________________________ Retired_____________

Employer's Address____

Insurance Name _______________________ID _________________Group___________

____

Subscriber Name Date of Birth Relation

2nd Insurance _________________________ID _________________Group___________

____

Subscriber Name Date of Birth Relation

3rd Insurance __________________________ ID ________________Group___________

____

Subscriber Name Date of Birth Relation

I authorize the release of any medical information necessary to process all claims.
I authorize the release of payment or medical benefits to my physician.

Patient's Signature______________________________________ Date________________