PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be confidential. Filing claims to your insurance is a courtesy. If you are unable to fill this out entirely, we may refuse to file claims for you and payment will be due same day.

Patient Name: _____ Date: _____

SSN: _____ Birthdate: _____ State of birth: _____ Male ☐ Female ☐

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Can we call your cell phone? _____

☐ By providing my phone number, I consent to receive SMS text messages from Illinois Retina & Eye Associates for appointment reminders, marketing messages and general two-way communication. Msg frequency varies. Msg & data rates may apply. Reply HELP to support. Reply STOP to opt out. View our Terms and Conditions and Privacy Policy at https://illinoisretinaandeyeassociates.com/

Email: _____ May we email medical correspondence? _____

Please check appropriate box: Minor ☐ Single ☐ Married ☐ Widowed ☐ Other ☐

Race: _____ Ethnicity: Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐

Mother's maiden name: _____

Employer: _____ Work phone: _____

Person to contact in case of an emergency: _____ Relationship to you: _____

Address: _____ Phone: _____

Preference for appointment confirmation for future use? Phone call ☐ Text ☐ Email ☐

Where did you first hear of our practice? _____

RESPONSIBLE PARTY

Name of person responsible for this account if not patient: _____

Relationship to patient: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____

Name of insured: _____ Relationship to patient: _____

Date of birth: _____ SSN: _____ Group number: _____

Secondary Insurance: _____

Name of insured: _____ Relationship to patient: _____

Date of birth: _____ SSN: _____ Group number: _____

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