PACIFIC RETINA CARE®

Mark E Tafoya, MD

Confidential Information

PATIENT INFORMATION:

Patient Name: _____ Nickname: _____

Address: _____

City, State, Zip: _____

Date of Birth: _____ M ☐ F ☐ Student Status: Full Time ☐ Part Time ☐

Marital Status: S☐ M☐ D☐ W☐ Other☐ Social Security Number: _____

Home Phone: ( )_____ Cell Phone: ( )_____

Occupation: _____ E-mail: _____

I do not have/refuse to share an email address. _____(initial) _____(date)

Employer: _____ Work Phone: ( )_____

Work Address: _____

City, State, Zip: _____

Referred By: _____ Driver's License #: _____

Primary Care Physician: _____ PCP Office Location: _____

If married or legal guardian please complete below:

Name: _____ Relationship: _____
DOB: _____ SS#: _____
Work Phone: ( ) _____

INSURANCE INFORMATION:

Insurance Company: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Sex: M ☐ F ☐ Subscriber's Relationship to patient: _____

Insurance Company: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's DOB: _____

Subscriber's Sex: M ☐ F ☐ Subscriber's Relationship to patient: _____

Workman's Comp. Claim? Yes ☐ No ☐ Ins. Carrier: _____

Date of Injury: _____ Auto Accident? Yes ☐ No ☐

If Subscriber's address is different from patient please fill out below:

Address: _____

Phone: ( ) _____

RESPONSIBLE PARTY INFORMATION:

Name of Responsible Party: _____

Address: _____

City, State, Zip: _____

Phone: ( )_____ Date of Birth: _____ M ☐ F ☐

Social Security: _____ Student Status: Full Time ☐ Part Time ☐

Occupation: _____ Employer: _____

Address: _____

City, State, Zip: _____

Work Phone: ( )_____ext. _____ Cell Phone: ( )_____

Marital Status: S☐ M☐ D☐ W☐ Other☐ E-mail: _____

Emergency Contact: _____

Relationship: _____ Phone: ( ) _____

I authorize release of confidential medical information to the following contact persons:

Name: _____ Name: _____

Phone: ( )_____ Phone: ( )_____

Relationship: _____ Relationship: _____

I verify that the above information is correct.

Signature of Patient/Legal Guardian: _____ Date: _____

I authorize/refuse to authorize Pacific Retina Care℠ to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes (circle all that apply):

Home Telephone Home Answering Machine Cell Phone/Voice Mail Work Phone/Voice Mail Email

Signature of Patient/Legal Guardian: _____ Date: _____