Northeast Wisconsin **Retina** Associates, SC

First name _____ Last name _____ Middle initial _____

Gender: ☐ Male ☐ Female Date of birth _____ SS# _____

Address _____

City _____ State _____ Zip _____

Billing address (if different) _____

Home phone _____ Work phone _____ Cell _____

Email _____ Preferred contact number: ☐ Home ☐ Work ☐ Cell ☐ Email

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Race _____ Marital status _____

Ethnicity _____ Preferred language _____

Emergency contact name _____ Phone _____ Relationship _____

Employer _____ Occupation _____

If married, spouse name _____ Phone _____

Referring doctor name _____

Address _____ Phone _____

Primary care doctor name _____

Address _____ Phone _____

General ophthalmologist name _____

Address _____ Phone _____

Specialist name _____ Specialty _____

Address _____ Phone _____

Patient name _____ **DOB** _____

If you have a Medicare card, even if you are not currently sending claims to Medicare, we need the ID number to access the "Medicare Eligibility Files" online.

Medicare ID Number (please bring card to scan) _____

Primary Medical Insurance Company (please bring card to scan) _____

Policy # _____ Group # _____

Subscriber's name _____ Subscriber's date of birth _____

Subscriber's Social Security # _____ Subscriber's relationship to patient _____

Subscriber's employer _____
Name of employer, city and state

Secondary Medical Insurance Company (please bring card to scan) _____

Policy # _____ Group # _____

Subscriber's name _____ Subscriber's date of birth _____

Subscriber's Social Security # _____ Subscriber's relationship to patient _____

Subscriber's employer _____
Name of employer, city and state

If the patient is a minor, please list both parents' names, phone numbers and addresses on the lines below:

Mother's first name _____ Last name _____ Phone_____

Address _____

City _____ State _____ Zip _____

Father's first name _____ Last name _____ Phone _____

Address _____

City _____ State _____ Zip _____

_____

Signature of Patient / Parent / Guardian Date