Retina Associates of CLEVELAND
YOUR SIGHT • OUR VISION

Today's Date: ____/____/____

New Patient Registration Form

Patient Information

Patient Name: _____ Sex: _____

Date of Birth: ____/____/_____ **Social Security #: _____**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Address: _____ City: _____

State: _____ Zip: _____ **Home Phone #: _____**

Email Address: _____ Cell Phone #: _____

Do we have your permission to leave a message on the devices above or with someone who answers them? ☐ Yes ☐ No

How would you prefer to receive appointment reminders? (please select one)
☐ Phone ☐ Text ☐ Email

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Patient Declined

Language Preferred: _____

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White ☐ Patient Declined

Medical History

Referring Eye Doctor and City Seen at: _____

Primary Care Doctor and City Seen at: _____

Any Other Eye Doctor: _____

Emergency Information

Emergency Contact: _____ Phone #: _____

Relationship: _____

Pharmacy Information

Pharmacy Name: _____ Address: _____ City:_____

If the name of the policy holder on the insurance is different than the patient, what is his/her date of birth? ____/____/____