Patient Registration form

7695 Cardinal Court, Suite 100
San Diego, CA 92123

3231 Waring Court Suite S
Oceanside, CA 92056

First Name	MI	Last Name	Sex
Home Address	City	State	Zip
Home Phone ( )	Work Phone ( )	Cell Phone ( )	

Preferred contact method for appointment or recall reminders: ☐ **Home phone** ☐ **Text** ☐ **Mobile phone** ☐ **email**

Date of Birth / /	Age	Social Security Number	Marital Status ☐ S ☐ M ☐ D ☐ W	E-mail address
Emergency Contact Name	Phone Number ( )	Relationship		
Patients Employer/Occupation	Financially Responsible Person	Relationship		
Financially Responsible Person Address (if different)	Home Phone ( )	Work or Cell Number ( )		
Is Patient In Skilled Nursing Facility? ☐ Yes ☐ No	Name and Address of facility	Facility Phone Number ( )		
Referring Physician Name	Phone Number ( )			
Primary Care Physician Name	Phone Number ( )			
Primary Insurance Carrier	Medical Group			
Subscriber Name	Subscriber ID	Date of Birth / /		
Policyholder Name	Policyholder SSN	Date of Birth / /		
Secondary Insurance Carrier	Medical Group:			
Subscriber Name	Subscriber ID	Date of Birth / /		
Policyholder Name	Policyholder SSN	Date of Birth / /		

I hereby authorize San Diego Retina Associates to disclose my medical and billing information to:

1. ______________________________ ______________________________

2. ______________________________ ______________________________

Please print name Indicate relationship

☐ I hereby give authorization for payment of Medicare and/or any other insurance benefits to be made directly to San Diego Retina Associates for services rendered.

☐ I hereby authorize release of any medical information necessary to secure payment of benefit.

☐ I hereby acknowledge I have received the San Diego Retina Associates Notice of Privacy Practices.

Patient Signature (or person authorized to sign) Relationship to patient

Printed Name: Date: