Date Completed: _____

Retina Associates of Kentucky
Patient Registration Form

Name _____ Date of birth _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Is this address for a nursing home? Yes / No If yes, name of nursing home _____

Gender _____ Marital Status _____ Home Phone _____ Cell _____

Email address for Patient Portal enrollment and announcements: _____

____ I do not have an email address. ____ I have an email address but I decline to participate at this time.

Emergency Contact Name _____ Phone _____ Relation _____

Employer _____ Phone _____ Veteran Yes / No

Language _____ Ethnicity ____ Hispanic or Latino ____ Non-Hispanic of Latino

Race ____ Caucasian / White ____ Black or African American ____ Asian ____ Multiracial

____ American Indian or Alaska Native ____ Native Hawaiian or Other Pacific Islander

Responsible Party Information for Minor Patients

Name _____ Date of birth _____ SS# _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Relationship to Patient _____

Primary Insurance _____

ID # _____ Group # _____

Subscriber information if other than self

Name _____ DOB _____

SSN _____ Relation _____

Secondary Insurance _____

ID # _____ Group # _____

Subscriber information if other than self

Name _____ DOB _____

SSN _____ Relation _____

Medicare patients: Are you or your spouse covered by any employer group health benefit plan? Yes / No

Is today's visit related to a work or automobile injury? Yes / No

Date of last hospitalization _____ Length of stay _____

Who may we discuss your health information with? ____ No one other than self

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Who referred you to our office? _____ Phone _____

Primary Care Physician _____ Phone _____

TURN OVER ⇨