RETINACENTER
OF CHICAGO

PATIENT INFORMATION SHEET
(Please Print Clearly)

Name:_____ Sex: ☐ M ☐ F Birthdate: ____/____/_____
Last First MI

Marital Status: ☐ Married ☐ Single ☐ Widowed

Mailing Address: _____ City, State, Zip: _____
Email Address: _____ Home Phone #: _____
Cell #:_____

Primary Care Doctor:_____ Name, Town, Street: _____
Phone #: _____

Referred By: _____

Preferred Pharmacy:_____ Name, Town, Street: _____

Occupation: _____
Business Phone #: _____ Employer: _____

Responsible Party: _____ Phone#: _____
Relationship:_____

Emergency contact: _____ Phone#: _____
Relationship:_____

I hereby authorize Retina Center of Chicago to release all medical information regarding my illness, care and/or injury to my insurance carriers, any health care facility, and any other physician that would benefit my health care. I hereby assign to Retina Center of Chicago all payment to which I am entitled for medical/surgical expenses related to the service reported from the above.

I hereby authorize Retina Center of Chicago to take photographs of my eyes for the sole purpose of research, education, and journal publication. I understand that these photographs will be anonymized and will not contain any of my personal information.

I understand I am financially responsible to Retina Center of Chicago for all charges, whether or not they are paid by said insurance. A photocopy of this assignment is as valid as the original.

Date: _____ Signature: _____
(Parent or Guardian if minor)