RETINA VITREOUS ASSOCIATES OF FLORIDA

PATIENT INFORMATION

➢ Please print and provide complete information for each item. ➢

Legal Name
First Name: _____ **MI:** _____ **Last Name:** _____

Local Address 1: _____

Local Address 2: _____ **City, ST Zip:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

DOB: _____ **Sex:** _____ **SS #:** _____ **Marital Status:** _____

Spouse Name: _____ **Spouse DOB:** _____

Referred by: _____ **Phone #:** _____

Address: _____ **City, ST Zip:** _____

Primary Dr: _____ **Phone #:** _____

Address: _____ **City, ST Zip:** _____

Emergency Contact (other than spouse): _____

Phone #: _____ **Relationship to Patient:** _____

Secondary Address: _____

City, ST Zip: _____ **Phone #** _____

If Patient is a Minor or Dependent:

Name of Responsible Party: _____

Phone #: _____ **Relationship to Patient:** _____

Address 1: _____

Address 2: _____ **City, ST Zip:** _____

Accident Related? _____ **Other:** _____

What Happened? _____

Person to Contact: _____ **Phone #:** _____

I authorize the physicians and staff of Retina Vitreous Associates of Florida to dilate, test and examine my eyes to the extent necessary to determine the underlying cause of my visual difficulties and to offer possible treatment options available to me.

PATIENT'S SIGNATURE:

Patient/Guardian Signature: _____ Date: _____