

LONG ISLAND & QUEENS
VITREO-RETINAL CONSULTANTS, P.C.

PLEASE PRINT AND USE BLACK INK

Last Name:_____ First Name:_____ (Mr. Ms. Mrs. Dr.)

Date of Birth:_____ Social Security #_____ Sex: M__F__

Home Phone #:(____)_____ Cell Phone #:(____)_____

Marital Status: Single__ Married__ Widowed__ Divorced__ Other__

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Street Address (if different from mailing address)_____

City:_____ State:_____ Zip Code:_____

Employed: Yes__ No__

Student: Yes__ No__

Name of Employer / School:_____

Address:_____ Phone #:(____)_____

City:_____ State:_____ Zip Code:_____

Emergency Contact Information

Name:_____ Relation:_____

Phone #:(____)_____ Alternate Phone #:(____)_____

***** PLEASE COMPLETE REVERSE SIDE *****

Doctor Information

Who Referred You To Our Practice? _____

Ophthalmologist / Optometrist

Name: _____

Address: _____ Phone #(____) _____

City: _____ State: _____ Zip Code: _____

Medical Doctor / Internist

Name: _____

Address: _____ Phone #:(____) _____

City: _____ State: _____ Zip Code: _____

Insurance Information

Please Fill Out The Following Information If Insured Party Is Other Than Patient

Primary Insurance: _____ Policyholder: _____

Date of Birth: _____ Social Security #: _____

Relation to Patient: _____ Employer: _____

Secondary Insurance: _____ Policyholder: _____

Date of Birth: _____ Social Security #: _____

Relation to Patient: _____ Policyholder: _____

Responsible Party If Other Than Self: (Balances, Co-pays, Deductibles)

Name: _____ Relation: _____

Address: _____ Phone #(____) _____

IS YOUR VISIT **NO FAULT** OR **WORKER'S COMPENSATION** RELATED? YES NO
IF YES, PLEASE SEE RECEPTIONIST FOR ADDITIONAL PAPERWORK