

**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: _____

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Emergency Contact (other than spouse): \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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Secondary Address: \_\_\_\_\_

City, ST Zip: \_\_\_\_\_ Phone # \_\_\_\_\_

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If Patient is a Minor or Dependent:

Name of Responsible Party: \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_ City, ST Zip: \_\_\_\_\_

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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: \_\_\_\_\_