**PATIENT REGISTRATION FORM (REGISTRO DE PACIENTE)**

**(Please Print)/ (Letra De Molde Por Favor)**

**Patient’s Name** (Nombre de Paciente): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** (Fecha): \_\_\_\_\_\_\_\_\_\_\_\_\_

**Birthdate** (Fecha de Nacimiento): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender** (Sexo): \_\_\_\_\_\_\_\_

**Social Security Number** (# de Seguro Social): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Marital Status** (Estado Civil): \_\_\_\_\_\_\_\_\_\_

**Home** **Phone or Preferred Phone** (Telefono de Domicilio): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Language** (Idioma Preferido): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone** (Telefono de trabajo): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address/ Street** (Direccion/ Calle): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City** (Ciudad): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State** (Estado): \_\_\_\_\_\_\_ **Zip Code** (Codigo Postal): \_\_\_\_\_\_\_\_\_\_\_\_

**Occupation** (Ocupacion): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer** (Empleado): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer’s Address** (Direccion de Empleado): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employer’s Phone number** (Telefono de Empleo):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance** (Aseguranza Principal): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy #** (# Poliza):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #** (# de Groupo)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance** (Aseguranza Secundaria): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Policy #** (# Poliza):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Group #** (# de Groupo)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person Responsible for Bills** (Persona responsible por el cobro): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship (Relacion): \_\_\_\_\_\_\_\_\_

**Primary Care Physician (Medical Doctor**)/ Doctor General: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Doctor’s Address (Direccion de Doctor General)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Doctor’s Phone number** (# Telefono): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax Number** (# de Fax): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient referred to this office by** (Quien lo Refiro Aqui): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is this visit the result of a work-related accident?** (Si es Accidente Relacionadao con El Trabajo) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact** (Persona a Contactar en Caso de Emergencia): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone** (Telefono en Caso de Emergencia): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Lake Shore Retina to release any information required in the course of my examination or treatment. I hereby assign to Lake Shore Retina, where applicable, all payment of medical services, not to exceed the stated charges.

**For medical care not covered by your insurance including co-pays or deductibles,** **payment is due at the time of visit.** It is your responsibility to bring any required referrals or authorizations for treatment at the time or prior to the visit. A copy of this authorization shall be as valid as the original.

Yo autorizo a Lake Shore Retina, S.C. que se provea cualqiuer informacion medica necesaria en el proceso de mi examen o tratamiento. Yo asigno a Lake Shore Retina, S.C., en caso, todo de los pagos de los servicios medicos. **Para la atencion medico no cubiertos por su seguro incluyendo copagos o deducibles, el pago es debido en el momento de la cita**. Es su responsibilidad tratar a cualquier referencia o authorizados necesarios para el tratamiento antes de su cita. Una copia de esta authorizada sera tan valida como el original.

**Patient Signature** (Firma del Paciente): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** (Fecha): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_