SALT LAKE RETINA

Patient Demographic Information

(Please print clearly and complete entire form)

General Information

Name _____ **Date of birth** _____/_____/_____ **Age** _____ **Sex** M / F

Street address _____ **City** _____ **State** _____ **Zip** _____

SSN _____ **Marital Status** *circle* Single Married Divorced Widowed

Cell phone *required* (_____)_____-_____ **Home phone** (_____)_____-_____

Email address *required for patient reminders* _____

Preferred language _____ **Ethnicity** *circle* Hispanic/Latino ***OR*** Not Hispanic/Latino

Race *circle one of the below options*

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Other race
- Decline to specify

Insurance Information

Primary Insurance

Carrier _____ Policy holder name _____

Policy number/Subscriber ID _____ Group number _____

Policy holder date of birth _____/_____/_____ Policy holder relationship to the patient _____

Secondary Insurance

Carrier _____ Policy holder name _____

Policy number/Subscriber ID _____ Group number _____

Policy holder date of birth _____/_____/_____ Policy holder relationship to the patient _____

Responsible Party (required for all patients under 18)

Name _____ Birthdate _____/_____/_____

Street address _____ City _____ State _____ Zip _____

Phone number (_____)_____-_____ Relationship to patient _____