RETINA CENTER OF MINNESOTA

Patient Name:_____ **Birthdate**:_____

Address:_____ **Social Security Number**:_____

City:_____ **State**:_____ **Zip Code**:_____

Primary Phone:_____ **Secondary Phone**:_____ **Work Phone**:_____

May we leave a detailed message at/with person answering: (Circle) Primary Secondary Work

Gender: (Circle) Male Female **Email Address**:_____

Sexual Orientation: (Circle) Heterosexual Homosexual Bisexual Something Else Don't Know Decline to Answer

Gender Identity: (Circle) Male Female Transgender Other Decline to Answer

Race: (Circle) American Indian Asian Black/African American Native Hawaiian/Pacific Islander White Other Decline

Language:_____ **Ethnicity**: (Circle) Hispanic/Latino Not Hispanic/Latino Unknown Decline

Marital Status: (Circle) Single Married Widowed Divorced Decline

Employment Status: (Circle) Student Full Time Part Time Retired Self

Occupation:_____ Employer_____

Employer Address_____ Phone:_____

Responsible Party: (Circle) Self Other If Other, please provide name & birthdate:_____

Emergency Contacts: **Ok to discuss care?**

Name/Relationship:_____ Phone_____ Yes No

Name/Relationship:_____ Phone_____ Yes No

Referring Eye Doctor/Clinic

Physician:_____ Clinic:_____

Address:_____

Phone:_____ Fax:_____

Primary Care Physician/Clinic

Physician:_____ Clinic:_____

Address:_____

Phone:_____ Fax:_____

Signature:_____ Date:_____

Relationship:_____ Chart#:_____