University Eye Specialists, LTD

676 North St. Clair, Suite 1500
Chicago, IL 60611
P: (312)475-1000

1535 Lake Cook Rd., Suite 305
Northbrook, IL 60062
P: (847)562-4330

NEW PATIENT REGISTRATION FORM

Doctor (circle one): Dr. Rosenberg Dr.Ruderman Dr. Yang Dr. Cervantes

Name:_____Sex: M F

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____Cell Phone:_____

Date of Birth:_____Social Security #:_____-_____-_____

Occupation:_____

Employer Name:_____

Ethnicity / Race: _____

E-mail Address:_____

Patient Relationship to Person Responsible for Account (circle one):

Self Spouse Son Daughter No Relation

EMERGENCY CONTACT (whom may we release medical information to?)

Name:_____ Relationship:_____ Phone #:_____

ACCOUNT RESPONSIBLE INFORMATION

***PLEASE COMPLETE THE FOLLOWING SECTION IF THE PERSON RESPONSIBLE IS SOMEONE OTHER THAN THE PATIENT.

Name:_____Sex: M F

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Work Phone:_____Ext:_____

Date of Birth:_____Social Security #:_____-_____-_____

INSURANCE INFORMATION

***IF YOUR INSURANCE CARDS ARE AVAILABLE FOR US TO COPY, YOU DO NOT NEED TO FILL OUT THIS SECTION.

PRIMARY INSURANCE COMPANY:_____

Name of Insured (if other than self):_____

ID/SS#:_____Group #:_____

Group Name:_____

SECONDARY INSURANCE COMPANY:_____

Name of Insured (if other than self):_____

ID/SS#:_____Group #:_____

Group Name:_____

REFERRAL SOURCE

Who referred you to our office? (circle one): Primary Care Doctor Ophthalmologist Friend Optometrist Insurance Co. Yellow Pages Northwestern Referral Service

Name of Referral Source:_____

Address of Referral Source:_____

City:_____State:_____Zip:_____

Referral Source Phone #:_____

MEDICAL DOCTOR INFORMATION

Medical Doctor Name:_____

Medical Doctor Address:_____

City:_____State:_____Zip:_____

Medical Doctor Phone #:_____ Fax #:_____

Medical Doctor Email Address (if known):_____

Thank you very much for your cooperation.