



COMPREHENSIVE EYECARE PHYSICIANS, P.C.

Ophthalmologists affiliated with Rosin Eyecare

JONATHAN ROSIN, M.D.

Comprehensive Ophthalmology  
Refractive Surgery  
Cataract Surgery

JIHAN AKHTAR, M.D.

Comprehensive Ophthalmology  
Glaucoma Management  
Cataract Surgery

AMY W. VANDENBROOK, M.D.

Comprehensive Ophthalmology  
Cataract Surgery

WILLIAM REIFF, M.D.

Comprehensive Ophthalmology  
Glaucoma Management

MARLYN GOLDBERG, M.D.

Vitreoretinal Diseases and Surgery

**Comprehensive Eyecare Physicians Confidential Internal Patient Registration Form**

<b>Patient Information</b>	
Name: ( ) _____ Today's Date: _____ <small>(Title) First Middle Initial Last</small>	
Address: _____ Birthdate: ____/____/____	
City _____ State _____ Zip Code _____ SSN: XXX-XX-_____	
Home Phone # ____/____/____ Daytime Phone # ____/____/____ Cell Phone # ____/____/____	
E-Mail Address: _____ Occupation: _____ Gender: M / F	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Employment Status: <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Retired <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unknown Employer: _____	
<b>Referred By:</b> <input type="checkbox"/> Walk In <input type="checkbox"/> Recall <input type="checkbox"/> Insurance Company <input type="checkbox"/> Phone Book _____ <small>Referral Persons Name</small>	
<input type="checkbox"/> Internet <input type="checkbox"/> Coupon/Mailer <input type="checkbox"/> Employee <input type="checkbox"/> Patient <input type="checkbox"/> Professional	
Emergency Contact Person _____ Best Contact # ____/____/____ wk / cell / home	Preferred Language: English Spanish Other _____ Race: Am Indian Asian African American Hispanic Caucasian Ethnicity: Hispanic/Latino Native Hawaiian/Pacific Not Hispanic
<b>Insurance Information</b>	Vision Insurance: _____
Relationship To Insured Party:	Medical Insurance: _____
<input type="checkbox"/> Self	Employer Name: _____
<input type="checkbox"/> Spouse	Primary Card Holder Name: _____
<input type="checkbox"/> Dependent Child	Birthdate of Primary Card Holder: ____/____/____
<input type="checkbox"/> Other _____	ID # or SS # _____ Group # _____
<b>Person Responsible for Payment (if minor)</b>	<b>Primary Card Holder Address (if differs from above)</b>
_____	_____
Secondary Insurance Name: _____	_____
ID #: _____	_____

Updates: Initials \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

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6233 West Cermak Road Berwyn, IL 60402 phone (708) 749-2020 fax (708) 749-2069

645 N. Michigan Ave. Suite 210 Chicago, IL 60616 phone (312) 787-2020 fax (312) 787-2374

145 Ogden Avenue Downers Grove, IL 60515 phone (630) 971-2020 fax (630) 964-2211 • 1917 Cherry Lane Northbrook, IL 60062 phone (847) 564-2020 fax (847) 564-2064

1435 N. Randall Road, Suite 102 Elgin, IL 60123 phone (847) 841-8866 fax (847) 841-8986