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

Patient Information

Name:( )_____ Today's Date:_____
(Title) First Middle Initial Last

Address:_____ Birthdate:____/____/_____

_____ SSN: XXX-XX-_____
City State Zip Code

Home Phone # _____/_____/_____ Daytime Phone # _____/_____/_____ Cell Phone # _____/_____/_____

E-Mail Address:_____ Occupation:_____ Gender: M / F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employment Status: ☐ FT ☐ PT ☐ Retired ☐ Self-Employed ☐ Unknown

Employer: _____

Referred By: ☐ Walk In ☐ Recall ☐ Insurance Company ☐ Phone Book _____
Referral Persons Name

☐ Internet ☐ Coupon /Mailer ☐ Employee ☐ Patient ☐ 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

Insurance Information

Relationship To Insured Party:
☐ Self
☐ Spouse
☐ Dependent Child
☐ Other _____

Vision Insurance: _____
Medical Insurance: _____
Employer Name:_____
Primary Card Holder Name: _____
Birthdate of Primary Card Holder: ____/____/_____
ID # or SS # _____ Group # _____

Person Responsible for Payment (if minor)

_____

Primary Card Holder Address (if differs from above)

_____

Secondary Insurance Name: _____
ID # : _____

_____

Updates: Initials_____ Date_____ Initials_____ Date_____ Initials_____ Date_____