



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
Glaucoma Management
Cataract Surgery

MARLYN GOLDBERG, M.D.

Vitreoretinal Diseases and Surgery

MICHAEL P. WEISBERG, M.D.

Comprehensive Ophthalmology
Glaucoma Management
Cataract Surgery

Comprehensive Eyecare Physicians Confidential Internal Patient Registration Form

Patient Information	
Name: () _____ (Title) First Middle Initial Last	Today's Date: _____
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: _____
Referred By: <input type="checkbox"/> Walk In <input type="checkbox"/> Recall <input type="checkbox"/> Insurance Company <input type="checkbox"/> Phone Book _____	Referral Persons Name _____
<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
Insurance Information	
Relationship To Insured Party: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> 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 _____

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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
15172 S. La Grange Rd. Orland Park, IL 60462 phone (708) 590-7650 fax (708) 737-7788