COMPREHENSIVE EYECARE PHYSICIANS, P.C.

*Ophthalmologists affiliated with Rosin Eyecare*

JONATHAN ROSIN, M.D.
Comprehensive Ophthalmology
Refractive Surgery
Cataract Surgery

AMY W. VANDENBROOK, M.D.
Comprehensive Ophthalmology
Glaucoma Management Cataract Surgery

MICHAEL P. WEISBERG, M.D.
Comprehensive Ophthalmology
Glaucoma Management
Cataract 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 ☐ Internet ☐ Coupon /Mailer ☐ Employee ☐ Patient ☐ Professional

________________________
**Referral Persons Name**

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__________

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