New Patient Registration Form

CAPITAL REGION RETINA, PLLC

Patient Name

Address

Home Phone Work Phone

Cell Phone Email Address

OK to leave a message? ☐ Yes ☐ No

Preferred Route of Contact ☐ Home # ☐ Work # ☐ Cell # ☐ Email

Would you like access to the Patient Portal? ☐ Yes ☐ No

Date of Birth Sex ☐ Male ☐ Female

Social Security #

Race

Ethnicity

Language (primarily spoken at home)

Referring Doctor

Primary Doctor

Any Other Doctors

Occupation

Pharmacy Name

Pharmacy Location

Protected Health Information Disclosure (people we may speak to about your care)

Name Relationship

Restrictions

I give permission for Capital Region Retina to access my medication history through Surescripts.

Signature Date