Deglin & Greene
RETINAL CENTER
EDWARD A. DEGLIN, MD • JOSHUA M. GREENE, MD
Preserving vision with trusted, innovative & compassionate care

Patient Registration

Welcome to our office. We hope we can provide the services you are seeking. There is certain information that we will need to render you the most efficient care. All information is confidential and will be maintained as part of your medical record. Please Print Clearly. Thank you.

PATIENT INFORMATION:

Patient's Name _____ Home Phone_____

Cell phone _____ Work Phone_____

Address _____ City _____ State____ Zip _____

S .S # _____ Date of Birth _____ Age _____ Sex _____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Driver's License # _____ Patient's Employer/School _____

Address _____ City _____ State____ Zip _____

Emergency Contact _____ Phone _____ Relationship _____

PARENT, GUARDIAN. OR SPOUSE INFORMATION: RELATIONSHIP_____

Name _____ Home Phone _____ Work Phone_____

Address _____ City _____ State____ Zip _____

Employer _____

Address _____ City _____ State____ Zip _____

S .S # _____ Date of Birth _____

FINANCIAL RESPONSIBLE PARTY: RELATIONSHIP_____

Name _____ Home Phone _____ Work Phone_____

Address _____ City _____ State____ Zip _____

Employer _____

Address _____ City _____ State____ Zip _____

S .S # _____ Date of Birth _____

The medical history I have given is honest, truthful, and complete. I authorize the doctor and staff to perform an examination for the purpose of diagnosis and treatment planning. I authorize the taking of photographs and/or other standard tests as required as a part of this examination. If necessary for medical or insurance purposes, I authorize release of information acquired in the course of my examination and treatment. I also give permission for the doctors to use photographs and other records of treatment in medical lectures or publications. I authorize payment of benefits to Edward A. Deglin, MD, PC.

Date: _____ Signature _____

Witness _____ Relationship to Patient _____