University Eye Specialists, LTD

676 North St. Clair, Suite 1500
Chicago, IL 60611
P: (312)475-1000

1535 Lake Cook Rd., Suite 305
Northbrook, IL 60062
P: (847)562-4330

NEW PATIENT REGISTRATION FORM

Doctor (circle one): Dr. Rosenberg Dr. Ruderman Dr. Yang Dr. Piper

Legal Name:_____ Sex: M F

Address: _____

City: _____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Social Security #:_____-_____- _____

Occupation:_____

Employer Name:_____

E-mail Address: _____

Ethnicity/Race: _____Preferred Language: _____

EMERGENCY CONTACT (whom may we release medical information to?)

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

ACCOUNT RESPONSIBLE INFORMATION

***PLEASE COMPLETE THE FOLLOWING SECTION IF THE PERSON RESPONSIBLE IS SOMEONE OTHER THAN THE PATIENT.

Patient Relationship to Person Responsible for Account (circle one):

Self Spouse Son Daughter No Relation

Name: _____ Sex: M F

Address:_____

City:_____State:_____Zip:_____

Home Phone:_____ Work Phone: _____Ext:_____

Date of Birth:_____ Social Security #: _____-_____-_____

REFERRAL SOURCE

Who referred you to our office? (circle one): Primary Care Doctor Ophthalmologist

Friend Optometrist Insurance Co. Yellow Pages Northwestern Referral Service

Name of Referral Source:_____

Address of Referral Source:_____

City:_____State:_____Zip:_____

Referral Source Phone #:_____

MEDICAL DOCTOR INFORMATION

Medical Doctor Name:_____

Medical Doctor Address:_____

City:_____State:_____Zip:_____

Medical Doctor Phone #:_____

Thank you very much for your cooperation.