

MICHIGAN RETINA-VITREOUS INSTITUTE  
1290 SOUTH LINDEN ROAD  
FLINT, MI 48532

PATIENT INFORMATION:

FIRST NAME: \_\_\_\_\_ MI: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL / WORK PHONE: \_\_\_\_\_ E-MAIL \_\_\_\_\_

Are you currently staying in a Skilled Nursing Facility?  No  Yes - \_\_\_\_\_

GENDER:  M  F    MARITAL STATUS  SINGLE  MARRIED  DIVORCED  WIDOWED

RACE:  Asian  Black  Caucasian / White  Decline / Unknown  Native Alaskan  Pacific Islander

ETHNICITY:  Hispanic  Non-Hispanic  Other

DATE OF BIRTH: \_\_\_\_\_ PREFERRED LANGUAGE: \_\_\_\_\_

PREFERRED CONTACT:  Phone Call  Fax \_\_\_\_\_  Postal Mail  E-mail

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ PHARMACY: \_\_\_\_\_

IF PATIENT IS A CHILD: MOTHER: \_\_\_\_\_ FATHER: \_\_\_\_\_

EMERGENCY CONTACT: (SOMEONE WE CAN CONTACT WHO DOES NOT LIVE WITH YOU)

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL / WORK PHONE: \_\_\_\_\_

EMPLOYMENT INFORMATION:

STATUS:  EMPLOYED  UNEMPLOYED  RETIRED  STUDENT  OTHER

EMPLOYER: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

STREET: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

**INSURANCE INFORMATION:**

GUARANTOR:  PATIENT     OTHER – Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**PRIMARY INSURANCE:**     Same as Patient     Same as Guarantor     Other

Company: \_\_\_\_\_ Patient's Relationship to Insured: \_\_\_\_\_

Insured Party: \_\_\_\_\_ Subscriber's Soc.Sec. #: \_\_\_\_\_

Insured ID: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Policy Group: \_\_\_\_\_

**SECONDARY INSURANCE:**     Same as Patient     Same as Guarantor     Other

Company: \_\_\_\_\_ Patient's Relationship to Insured: \_\_\_\_\_

Insured Party: \_\_\_\_\_ Subscriber's Soc.Sec. #: \_\_\_\_\_

Insured ID: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_\_

Policy Group: \_\_\_\_\_