

COLUMBIA OPHTHALMOLOGY CONSULTANTS

<input type="checkbox"/> Lama Al-Aswad, MD	<input type="checkbox"/> Stanley Chang, MD	<input type="checkbox"/> Thomas Flynn, MD	<input type="checkbox"/> Amilia Schrier, MD
<input type="checkbox"/> James D. Auran, MD	<input type="checkbox"/> Michael Chiang, MD	<input type="checkbox"/> Scott Smith, MD	<input type="checkbox"/> R.T. Smith, MD
<input type="checkbox"/> Gaetano Barile, MD	<input type="checkbox"/> Lucian Del Priore, MD	<input type="checkbox"/> Reza Iranmanesh, MD	<input type="checkbox"/> Stephen Trokel, MD
<input type="checkbox"/> Richard Braunstein, MD	<input type="checkbox"/> Linsy Farris, MD	<input type="checkbox"/> Leejee Suh, MD	<input type="checkbox"/> Stephen Tsang, MD
<input type="checkbox"/> Daniel Casper, MD	<input type="checkbox"/> John Flynn, MD	<input type="checkbox"/> William Schiff, MD	<input type="checkbox"/> Howard Fine, MD

PATIENT REGISTRATION INFORMATION

Date: _____ Social Security # _____ Hospital Unit # _____

Last Name: _____ First Name: _____ M.I. _____

Address: _____ Apt: _____ Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

DOB: _____ Age: _____ Gender: _____ Marital: Single / Married / Div / Sep / Widow

Mother's First Name: _____ Father's First Name: _____

Employer: _____ Business Phone: _____

Business Address: _____ City/St: _____ Zip: _____

Occupation: _____ Spouses Name: _____

Primary Care Physician: _____ Phone: _____

Address: _____ City/St: _____ Zip: _____

Referred By: _____

Emergency Contact: _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Primary Insurance

Primary Cardholder: _____

Relationship To Patient: _____ DOB: _____ SS# _____

Address: _____ City/St: _____ Zip: _____

Insurance Company Name: _____

Address: _____ City/St: _____ Zip: _____

Subscriber ID #: _____ Group#: _____ Co-Pay: \$ _____

Additional Insurance

Relationship To Patient: _____ DOB: _____ SS# _____

Address: _____ City/St: _____ Zip: _____

Insurance Company Name: _____

Address: _____ City/St: _____ Zip: _____

Subscriber ID #: _____ Group#: _____ Co-Pay: \$ _____

Signature Of Responsible Party: _____ Date: _____