RETINA CENTERS, P.C.
❒ GEORGE S. NOVALIS, M.D., F.A.C.S.
❒ MARTIN A. WORRALL, M.D., F.A.C.S.
❒ RYAN K. WONG, M.D.
❒ SHREE K. KURUP, F.A.C.P.

NORTHWEST
6585 N. Oracle Rd.
Tucson, AZ 85704
(520) 742-7444

EAST
2375 N. Wyatt Dr.
Suite 103
Tucson, AZ 85712

SOUTHWEST
1701 W. St. Mary's Rd.
Suite 111
Tucson, AZ 85745

GREEN VALLEY
1151 S. La Cañada Rd.
Suite 200
Green Valley, AZ 85614

NW E
SW GV

PATIENT INFORMATION (To be filled in completely -- please print) Date:_____

PATIENT NAME: _____ PHONE:_____
LAST FIRST MIDDLE

SEX: M F DO YOU SMOKE? Y N DATE OF BIRTH: _____ AGE:_____
Mo/Day/Year

MARITAL STATUS: S M W D SOCIAL SECURITY NO.: _____

White ____ Hispanic ____ Black ____ Native American Indian ____ Other ____

ADDRESS: _____
Street Apt# City State Zip

Out-of-town Address:_____
Street Apt# City State Zip

REFERRING DOCTOR: _____ **Location:** _____

PRIMARY CARE PHYSICIAN: _____ **Location:** _____

YOUR OCCUPATION: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____ zip:_____ PHONE: _____

NAME OF SPOUSE: _____ SPOUSE'S SOCIAL SECURITY #: _____

SPOUSE'S EMPLOYER: _____ PHONE: _____

NEAREST RELATIVE not living w/you: _____ Relationship: _____

ADDRESS: _____ PHONE:_____

INSURANCE INFORMATION: PLEASE PRESENT INSURANCE CARDS WITH THIS FORM TO RECEPTIONIST

RESPONSIBLE PARTY (if other than above) _____ PHONE: _____

PRIMARY INSURANCE: _____ _____ _____
Name Policy No. Group No.

SECONDARY INSURANCE: _____ _____ _____
Name Policy No. Group No.

AUTHORIZATION: I hereby irrevocably request that payment of authorized medical benefits be made directly to RETINA CENTERS, P.C., for services provided to me by the physicians of this practice. I also authorize release of medical information needed to determine these benefits. A photocopy of this authorization shall be considered as effective and valid as the original. Additionally, I approve the use of the phone number provided above to receive an appointment reminder call and/or other messages.

SIGNATURE:

_____