Registration Form

Retina Expert
Asheesh Tewari, MD

WAYNE STATE University Physician Group

Date _____

Patient Information

Patient Name: _____ Date of Birth: _____

Home Phone: _____Cell Phone: _____ Last Four Digits of SSN: _____

Address: _____City: _____

State:_____ Zip Code: _____ County: _____

Ethnicity: ❒ Hispanic, Latino or Spanish origin ❒ Non Hispanic, Non Latino or Non Spanish origin

Race: ❒ African American/Black ❒ Caucasian/White ❒ Middle Eastern ❒ Asian ❒ Greek ❒ Hispanic ❒ Indian ❒ More than one race ❒ Native American Indian ❒ Native Hawaiian or other Pacific Islander

Marital Status: ❒ S ❒ M ❒ D ❒ W **Gender:** ❒ M ❒ F

Preferred Language:_____ **Interpretor Need:** ❒ Y ❒ N

Insurance Guarantor: ❒ Self ❒ Parent ❒ Other_____

Patient Employer: _____ Occupation: _____

Employer's Address: _____Work Phone:_____

Preferred Method of Communication: ❒ Home ❒ Work ❒ Cell ❒ Portal ❒ Other:_____

Would like to receive appointment reminders and promotional text messages: ❒ Yes ❒ No

E-Mail Address:_____

Legal Guardian - 1

Name: _____

Relationship: _____

❒ Address Same as Patient

Address: _____

City:_____ State:_____ Zip:_____

Phone:_____Cell: _____

Legal Guardian - 2

Name: _____

Relationship: _____

❒ Address Same as Patient

Address: _____

City:_____ State:_____ Zip:_____

Phone:_____Cell: _____

Emergency Contact Name: _____

Emergency Contact Phone Number: _____ Relationship to Patient:_____

Do you have an **Advance Directive** or a formal document indicating who your Durable Power of Attorney is for health care decisions? ❒ Yes ❒ No

If no, would you like the physician to provide you information on Advance Health Care Directives? ❒ Yes ❒ No

Pharmacy

We are now able to transmit your prescriptions electronically. Please list your pharmacy information below:

Local Pharmacy: _____Phone Number: _____

Address: _____ City: _____

(street address if known or main road with closest cross street)

Mail Order Pharmacy: _____Phone Number: _____

Address: _____City: _____State: _____Zip Code: _____

How did you hear about us? ❒ Physician ❒ Family ❒ Friend ❒ Website ❒ Advertisement ❒ Attorney ❒ Other: _____

Registration Form

Primary Care Family Physician	**Referring Physician** ❒ Is My Primary Family Physician
Name: _____	Name: _____
Address: _____	Address: _____
City:_____ State:_____ Zip:_____	City:_____ State:_____ Zip:_____
Phone: _____	Phone: _____

Primary Insurance: _____Group # _____ ID# _____

Subscribers Relationship to Patient: ❒ Self ❒ Parent ❒ Spouse ❒ Other_____

Subscriber Name: _____

SSN of Subscriber if Veteran's Insurance: _____ Subscriber Date of Birth: _____

Sex of Subscriber: ❒ Male ❒ Female Subscriber Address: _____

City: _____ State: _____ Zip: _____

Secondary Insurance: _____Group # _____ID# _____

Subscribers Relationship to Patient: ❒ Self ❒ Parent ❒ Spouse ❒ Other _____

Subscriber Name:_____

SSN of Subscriber if Veteran's Insurance: _____ Subscriber Date of Birth: _____

Sex of Subscriber: ❒ Male ❒ Female Subscriber Address: _____

City: _____ State: _____ Zip: _____

Other Insurance: ❒ Vision ❒ Dental ❒ Other Medical _____

Subscribers Relationship to Patient: ❒ Self ❒ Parent ❒ Spouse ❒ Other_____

Subscriber Name: _____

SSN of Subscriber if Veteran's Insurance: _____ Subscriber Date of Birth: _____

If patient is being seen due to injury please complete the following:

_____ Injury at work Date:_____ From a ❒ lift ❒ twist ❒ fall ❒ bend ❒ pull ❒ reach

Claim number:_____

Name and number of case worker/adjuster: _____

_____ Auto Accident Date of Accident:_____ State of Injury: _____

Claim number:_____

Name and number of case worker/adjuster: _____

Patient Signature: _____Date: _____

Print Name(s) of Legal Guardian:_____Phone Number: _____

Responsible Party Signature: _____ Relationship: _____

(if patient is minor or has guardian)