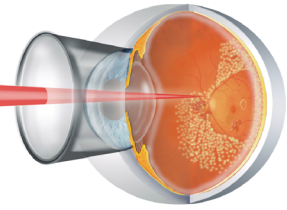


THE RETINA EYE CENTER

Leaders in vitreoretinal treatment, offering compassion, cutting-edge technology and hope

Randy Dhaliwal, MD, FRCSC, FACS
Oksana Maria Demediuk, MD, FACS



PATIENT INFORMATION SHEET

NOTE: BIRTHDATE AND SOCIAL SECURITY NUMBERS ARE REQUIRED TO FILE YOUR INSURANCE.

Full Name: _____
Last First MI

Male Female Single Divorced Married Widowed

Date of Birth: ____ / ____ / ____ Your Age Today: _____

Social Security Number: _____

Mailing Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

Home Telephone: _____ Work Telephone: _____

Responsible Party: _____ Relation: _____

Patient's Employer: _____

Patient's Occupation: _____ Retired: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact: _____
Name Telephone Number Relation

Referring Physician: _____ Primary Care Physician: _____

I authorize the release of any medical information necessary to process all claims. I authorize the release of payment or medical benefits to my physician.

Patient's Signature: _____ Date: _____