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Denton R Roberts, MD

PATIENT DEMOGRAPHIC FORM

Date _____ New Patient: Y N Updating Information: Y N

Last Name _____ First Name _____ MI _____ Nickname _____

SSN _____ Birthdate _____ Sex: M F Marital Status _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Email _____

Are you currently residing in a Skilled Nursing Facility? Y N Facility Name _____

Are you enrolled in a Hospice Program? Y N Date Enrolled _____

Patient's Family Physician _____ Address/Phone _____

Patient's Employer _____ Occupation _____

Employer's Address _____ Work Phone _____

Spouse's Legal Name _____ SSN _____ Birthdate _____

Address (if different) _____ Home Phone _____ Cell _____

Spouse's Employer & Address _____ Work Phone _____

Nearest Relative/Person Not Living with You _____

Relationship _____ Phone _____

How did you hear about Retina Specialists of Idaho, PLLC? _____

IF PATIENT IS A MINOR:

Presenting Guardian's Name _____ Birthdate _____

Address (if different from above) _____ SSN _____

Home Phone _____ Cell _____ Work Phone _____

Accounts Past Due Policy

If deemed necessary for non-payment your account may be sent to a third party collection agency. Any outstanding balance over 90 days will be subject to a one-time \$20 fee & 12% annual interest.