



Retina Specialists of New York, PLLC

Peter Condax, M.D. George Condax, M.D. Jeffrey J. Yu, M.D.

PATIENT INFORMATION (Please Print)

Name: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Email: _____ Preferred Language: _____

SS#: _____ Date of Birth: _____

Tel 1: _____ ☐cell/ ☐home Tel 2: _____ ☐cell /☐home/☐work

Contact preference for follow-up appointment reminders: ☐home phone ☐cell phone ☐mail

Sex: ☐M ☐F Marital Status: ☐Single ☐Married ☐Divorced ☐Widow

Race ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian or Other Pacific Islander ☐Hispanic ☐White ☐Decline to Answer

Emergency contact: _____ Relationship & Tel #: _____

How were you referred to the Practice? _____

Primary Care Doctor: _____

Referred by: _____

Telephone: _____

Telephone: _____

Address: _____

Address: _____

Primary Insurance: _____ Insurance Copay: \$ _____

Primary Insurance ID #: _____ Group #: _____

Name of Policy Holder: _____ Date of Birth: _____

Relationship to patient: Self__ Spouse__ Child__ Other__ SS #: _____

Policy Holder's Employer: _____ Telephone: _____

Secondary Ins: _____ Ins. ID: _____

Name of Policy Holder: _____ Date of Birth: _____

Pharmacy Name: _____ Tel. _____

Pharmacy Address: _____

Consent to Dilate and Treat: I understand that it will be necessary to dilate my eyes at each visit and give my consent for Peter Condax MD/George Condax MD/Jeffrey Yu MD and their assistants to administer dilating eye drops. I understand that my vision will become blurry (lasting about 4 hours) and therefore make it unsafe to drive. I will not attempt to drive until certain the effect of the medicine has worn off. Sunglasses are also advised.

Patient/Responsible Party Signature: _____ Date: _____