Diseases and Surgery of the Retina, Vitreous and Macula

Peter Condax MD George Condax MD

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: _____

Telephone: _____

Address: _____

Referred by: _____

Telephone: _____

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 Drs. Peter Condax MD/George Condax 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: _____