SARALYN NOTARO RIETZ, M.D.

PRACTICE LIMITED TO DISEASES OF THE VITREOUS AND RETINA

NEW PATIENT INFORMATION

WELCOME TO OUR OFFICE. Please complete all the pages of this form and return it to the receptionist, who will then use the information to prepare your chart.

PLEASE PRINT

Name_____Male/Female
First M.I. Last

Address_____
Street City State Zip

Date of Birth_____Social Security Number_____

Home Phone_____Work Phone_____

Cell Phone _____ E-Mail Address_____

Employer_____Occupation_____

Employer Address/Phone_____

Name/Phone of Referring Physician_____

Name/Phone of **Primary Physician**_____

Who to contact in case of emergency: (other than home #)

Name_____Relationship_____

Address_____

Home Phone_____Work Phone_____

Are you personally responsible for payment of your bill?_____YES _____NO If no, who is?

Name_____Relationship_____

Primary Insurance_____ Secondary Insurance_____

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