

**Veena Arun, M.D.**  
**University Ophthalmology**  
**1525 East 53<sup>rd</sup> Street, Suite 1002**  
**Chicago, IL 60615**  
**Ofc 773-288-2020**  
**Fax 773-324-3704**

Today's date:			PCP:			
<b>PATIENT INFORMATION</b>						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Race/Ethnicity	Email Address		Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street address:		Social Security no.:		Mobile phone no.: (    )		
P.O. box (if applicable)	City:	State:	ZIP Code:			
Occupation:	Employer:		Employer phone no.: (    )			
Chose clinic because/Referred to clinic by (please check one box):			<input type="checkbox"/> Dr. _____			<input type="checkbox"/> Insurance Plan <input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		

<b>INSURANCE INFORMATION</b>					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date:	Address (if different):		Home phone no.:	
	/ /			(    )	
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:
		/ /			\$
Patient's relationship to subscriber:		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other

Pharmacy:

<b>IN CASE OF EMERGENCY</b>			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		(    )	(    )
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize University Ophthalmology or insurance company to release any information required to process my claims.</p>			
Patient/Guardian signature			Date