Hilton Head Retina Institute

15 Lafayette Place, Suite C

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Carl W. Baker, MD

NAME First M.I. Last	**DOB**	**SSN**
STREET ADDRESS		**AGE**
CITY **STATE**	**ZIP**	**SEX** [ ] Male [ ] Female
PRIMARY PHONE	**OTHER PHONE**	**MARTIAL STATUS** [ ] Single [ ] Married [ ] Widowed
EMAIL ADDRESS		
EMERGENCY CONTACT NAME **RELATIONSHIP** **PHONE #**		

RACE [ ] Asian [ ] American Indian/Alaskan Native [ ] African American [ ] Native Hawaiian or other Pacific Islander [ ] Caucasian [ ] Other	**ETHNICITY** [ ] Hispanic or Latino [ ] Not Hispanic or Latino

INSURANCE: Are you the Policy Holder ?

[ ] Yes **** If yes, the following does not apply to you ****

[ ] NO – **If no, please fill out the following**

Policy Holder's Name: **DOB**:

Address: [ ] Same as listed *OR*

PHARMACY	**PRIMARY CARE PROVIDER**
EMPLOYER NAME & PHONE	

☐ **I give permission to Hilton Head Retina Institute to send me SMS text for information about my appointment(s) and medical care.**

Signature: _____ Date: _____