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*Denton R Roberts, MD*

**PATIENT DEMOGRAPHIC FORM**

Date \_\_\_\_\_ New Patient: Y N Updating Information: Y N

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Nickname \_\_\_\_\_

SSN \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: M F Marital Status \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Email \_\_\_\_\_

Are you currently residing in a Skilled Nursing Facility? Y N Facility Name \_\_\_\_\_

Are you enrolled in a Hospice Program? Y N Date Enrolled \_\_\_\_\_

Patient's Family Physician \_\_\_\_\_ Address/Phone \_\_\_\_\_

Patient's Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse's Legal Name \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different) \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Spouse's Employer & Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Nearest Relative/Person Not Living with You \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about Retina Specialists of Idaho, PLLC? \_\_\_\_\_

**IF PATIENT IS A MINOR:**

Presenting Guardian's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from above) \_\_\_\_\_ SSN \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ Work Phone \_\_\_\_\_

**Accounts Past Due Policy**

If deemed necessary for non-payment your account may be sent to a third party collection agency. Any outstanding balance over 90 days will be subject to a one-time \$20 fee & 12% annual interest.