

PATIENT INFORMATION

GLAUCOMA CONSULTANTS

Name (Last, First, MI)			
Sex	Date of Birth	Social Security#	
Home Phone ()		Marital Status	
Address	City	State	Zip
Occupation	Employer		
Work Address			
Work Phone CELL PHONE			

Referring Physician		Phone ()	
Referring Physician Address			
Medical Doctor		Phone ()	
Medical Doctor Address			
Emergency Name	Phone ()	Relationship	

Guarantor Information (Complete is other than patient)

Guarantor Name		Phone ()	
Guarantor Address			
Guarantor Social Security #		Relationship to Patient	
Guarantor Employer		Guarantor Date of Birth	
Work Address		Work Phone ()	

Primary Insurance

Ins. Name		Phone()	
Ins. Co. Address			
Name of Policy Holder		Relationship to Patient	
Policy #		Policy Holder Date of Birth	
Employer		Group Name	
Group Number		Effective Date	

Secondary Insurance

Ins. Name		Phone()	
Ins. Co. Address			
Name of Policy Holder		Relationship to Patient	
Policy #		Policy Holder Date of Birth	
Employer		Group Name	
Group Number		Effective Date	

By signing I attest the information is true and correct. I agree to be financially responsible for any services provided by Glaucoma Consultants if: insurance information is not correct, not covered by my plan, applied to co insurance or deductibles, or the required authorizations or referrals have not been obtained.

I authorize payment of insurance benefits to Glaucoma Consultants for services rendered during my entire course of treatment and care in accordance with the coverage provisions of my insurance contract.

I authorize the holder of my medical information to release to my insurance carrier, any information needed to determine these benefits. I permit this authorization to be used in place of original signature. The authorization, unless revoked by me or my guarantor in writing, will remain in my medical record for life.

Signature: _____ Date: _____