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:_____