Glaucoma Consultants of the Capital Region

Patient History & Registration form

Please complete this form and provide to our staff for our records.

PATIENT:

NAME: _____ DATE OF BIRTH:_____ MARITAL STATUS: _____

ADDRESS:_____AGE:_____ SEX: M F SS#:_____

CITY:_____ STATE: _____ ZIP: _____ PHONE: (H)_____(W) _____

EMPLOYER: _____ NEAREST RELATIVE: _____

EMPLOYER'S ADDRESS: _____ RELATIONSHIP TO YOU:_____

CITY:_____ STATE: _____ ZIP: _____ PHONE: (H)_____(W) _____

BILLING:

WHO IS RESPONSIBLE FOR THIS BILL? ❑ PATIENT ❑ OTHER _____

NAME: _____ RELATIONSHIP TO YOU:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

EMPLOYER: _____ SS#: _____

ARE YOU COVERED BY INSURANCE? ❑ YES ❑ NO

INSURANCE:

PRIMARY INSURANCE COMPANY: _____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

NAME OF INSURED:_____ D.O.B:_____ ID #:_____ GROUP #:_____

IS THIS A WORKMAN'S COMPENSATION CASE? ❑ YES ❑ NO IF YES, DATE OF ACCIDENT: _____

NAME OF COMPENSATION INSURANCE CARRIER:_____

ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

MEDICAL INFORMATION: ALLERGIES: ❑ NO ❑ YES: _____

WHAT MEDICAL PROBLEM BRINGS YOU HERE ?_____

PHYSICIAN:

REFERRING DOCTOR:_____

ADDRESS:_____

PHONE #: _____

FAMILY DOCTOR:_____

ADDRESS: _____

PHONE #: _____

AUTHORIZATION:

I hereby authorize my insurance benefits be paid directly to Glaucoma Consultants and acknowledge that I am financially responsible for any unpaid balance. I also authorize the physician to release any information required. *I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE.*

*Signature:*_____ *Date:* _____