Martin B. Kaback, MD
Ralph M. Sanchez, MD, MPH
Steven T. Simmons, MD
Michael J. Pokabla, DO
Albert M. Morier, OD

Glaucoma Consultants of the Capital Region

Last Name: _____ First Name: _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: (___)_____ Mobile Phone: (___)_____ Work Phone: (___)_____
Email Address: _____ Occupation: _____
Date of Birth: _____ Age: _____ Sex: M [ ] F [ ] Marital Status: _____
Emergency Contact: _____ Phone: (___)_____ Relationship: _____

Insurance Information

Primary Insurance: _____ ID#: _____ Group#: _____
City: _____ State: _____ Zip: _____ Phone: (___)_____
Primary Card Holder: _____ Date of Birth: _____ Relationship: _____
Card Holder Address: _____ City: _____ State:_____ Zip: _____

Secondary Insurance: _____ ID#: _____ Group#: _____
City: _____ State: _____ Zip: _____ Phone: (___)_____
Primary Card Holder: _____ Date of Birth: _____ Relationship: _____
Card Holder Address: _____ City: _____ State:_____ Zip: _____

Workers Compensation Insurance: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: (___)_____
Date of Incident: _____

Medical Information

Reason For Visit: _____
[ ] No Known Allergies [ ] Allergic to: _____
_____
Family Doctor: _____ Phone: (___)_____ Fax: (___)_____
Referring Doctor: _____ Phone: (___)_____ Fax: (___)_____
Local Pharmacy: _____ Phone: (___)_____ Fax: (___)_____
Mail Order Pharmacy: _____ Phone: (___)_____ Fax: (___)_____

I authorize Glaucoma Consultants of the Capital Region to disclose my personal information to the following people:
Name: _____ Phone (___)_____ Relationship: _____
Name: _____ Phone (___)_____ Relationship: _____
Name: _____ Phone (___)_____ Relationship: _____

Assignment and Release: I hereby authorize my insurance benefits be paid directly to Glaucoma Consultants of the Capital Region. I acknowledge that I am financially responsible for any unpaid balances. I also authorize the physician to release any information required. **I understand that I am responsible for all charges whether or not they are covered by insurance.**

Signature: _____ **Date:** _____