Illinois Glaucoma Center

ILLINOIS GLAUCOMA CENTER

Updates to Patient Registration (For Established Patients)

Patient Information

Name (Last, First MI) _____ **Maiden Name/Also Known As** _____

Social Security # _____ **Sex (Circle) M F** **Date of Birth** _____

Address (Street, City, State, Zip) _____

Marital Status (Circle One): Single Married Divorced Widowed Spouse Name _____

Home Phone Number_____ **Cell Phone Number** _____

Work Phone Number _____ **Email Address** _____

Race:

American Indian/Alaska Native ___ Asian___ African American/Black ___

Native Hawaiian/Pacific Islander___ White___

Ethnicity: Hispanic/Latino___ Not Hispanic/Not Latino___

Language (Circle those that apply):

English

Spanish

Polish

Chinese

German

Italian

Korean

Portuguese

Russian

Other

Preferred Method of Contact

Cell Phone___ Work Phone___ Home Phone___ Other _____

Patient or Legal Guardian Signature _____ **Date** _____

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Consent to Treatment and Release of Information

Unless otherwise directed below, if I am unavailable, the physician may communicate normal test results via home telephone, voicemail or answering machine to the home phone numbers on this form, as long as the nature of the call is not disclosed.

In addition, my normal test results may be communicated to _____ Relationship _____

No, I want my test results only communicated personally to me _____

I authorize examination and medical treatment, verification of benefits and the release of information (including the diagnosis and medical records) to other physicians involved in my care, to my insurance company to facilitate billing and reimbursement, and for quality assurance purposes. I acknowledge that I have been offered and received or declined to receive a copy of the HIPAA Notice of Privacy Practices. I authorize benefits to be paid directly to the physician and I understand that I am responsible for any unpaid balance under the terms of my insurance policy.

Patient or Legal Guardian Signature _____ Date _____