ILLINOIS GLAUCOMA CENTER

New Patient Registration Form

<u>Patient Information</u>

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	Italian
Spanish	Korean
Polish	Portuguese
Chinese	Russian
German	Other

Preferred Method of Contact

Cell Phone___ Work Phone___ Home Phone___ Other ____

How were you referred to this office?

Physician Referral/Family Physician____

Relative, Friend, Neighbor ____ Walk In/Drive By____ Urgent Aid____

Insurance Network ____ Letter/Mailing____ Other______________________

Ingalls/ISDS/MCX Employee____ Internet____

Care Connection____ Hospital/ER____

Employer's Information

Employer's Name_______________________________ Phone Number and Extension_____________________________

Street Address____ City, State, Zip____________________________________

Emergency Contact

Name (Last, First MI)____ Employer ________________________________

Home Phone________________________ Work Phone__________________________ Cell Phone___________________

Person Responsible for Payment if Other Than Patient

Name (Last, First MI) ____

Sex: M____ F____ **Relationship to Patient:**____

Street Address___________________________________ **City, State, Zip**__________________________________

Home Phone_______________________________ **Work Phone**_________________________________

Cell Phone_________________________________ **Alternate Phone**______________________________

Social Security Number_______________________________ **Date of Birth**__________________________________

Employer Name____

Employer Address____ **Employer Phone**___________________

Primary Insurance Company Name____

Secondary Insurance Company Name____

Pharmacy Information

Pharmacy Name____

Address (Street, City, State, Zip)____

Phone Number________________________________ Fax Number____________________________

Parent or Legal Guardian Signature____________________________________ **Date**_________________

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 ______________________

Form #030A

Revised 10/2012