Name: _____ DOB:_____/_____/_____

ILLINOIS GLAUCOMA CENTER

Updated Registration (For Established Patients ONLY)

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 _____

Preferred Method of Contact

Cell Phone___ Work Phone___ Home Phone___ Other _____

Patient or Legal Guardian Signature _____

Date _____

Who is your Family or **Primary Care Physician (PCP)?**

PCP Name:_____

PCP Phone Number:_____

PCP City and State:_____

Primary Insurance Company Name and Policy Number:_____

Secondary Insurance Company Name and Policy Number:_____

Name: _____ DOB:_____/_____/_____

Emergency Contact Information:

Name:_____

Relationship:_____

Phone Number:_____

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. **Initials _____**

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

Relationship _____

No, I want my test results only communicated personally to me. **Initials_____**

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. **Initials_____**

Patient or Legal Guardian Signature _____

Date _____