Name: ________________________________ DOB:______/________/_________

ILLINOIS GLAUCOMA CENTER

New Patient Registration Form

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

Other______________________

Preferred Method of Contact

Cell Phone___ Work Phone___ Home Phone___ Other ___________________________________

How were you referred to this office?

____

Name: ________________________________ DOB:______/________/_________

Employer's Information (if applicable)

Employer's Name__________________________ Phone Number and Extension_________________________

Street Address__________________________________ City, State, Zip______________________________

Emergency Contact

Name (Last, First MI)____

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_______________________________________

Name: _______________________________ DOB:______/________/_________

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