Patient Demographic

Patient Demographic Date: _____

Name: _____

DOB: _____

◯ Male
◯ Female

Address: _____

City: _____

State: _____ Zip: _____

Home Phone: _____ Cell: _____

Employer: _____

Status

☐ Full
☐ Part-time
☐ Retired
☐ Student
☐ Unemployed

Marital Staus

☐ Married
☐ Partner
☐ Other
☐ Single
☐ Divorced
☐ Widow
☐ Child

Emergency Contact: _____ Relationship to Patient: _____

Emergency Telephone: _____ Other Number(s): _____

Pharmacy Name: _____ Telephone Number: _____

Insurance: _____ID: _____ Group: _____

Subscriber Name: _____ DOB: _____

Relationship to Subscriber (Patient)

- ☐ Self
- ☐ Spouse
- ☐ Child
- ☐ Other

Insurance: _____ID: _____Group: _____

Subscriber Name: _____DOB: _____

Relationship to Subscriber (patient):

- ☐ Self
- ☐ Spouse
- ☐ Child
- ☐ Other

Referring Doctor Name: _____Telephone: _____

Primary Care Physician: _____Telephone: _____

Release of information: I authorize the release of any pertinent medical information to my insurance carrier, third parties or physicians involved with my treatment. I authorize assignment of benefits to Advanced Glaucoma Specialists and its agents.

Consent for Treatments: I authorize Advanced Glaucoma Specialists and its agents to assess my need for medical treatment, to prescribe and administer treatment deemed necessary for my health care. This may include oral, written and or electronic communications to the other providers and/or individuals to facilitate care on my behalf.

Office Policies: Advanced Glaucoma Specialists and its agents requires the payment of co-payments and coinsurances at the time of visit. Processed insurances deductibles and balances not covered by insurance are due upon request. Charges of $30 will be applied to all returned checks and $45 for appointments not cancelled within 24 hours of appointment. Procurement of insurance referrals is the responsibility of the patient.

The information provided is current as of today's date and if there are any changes I shall be responsible for providing updating of information. I have read and understand the above.

Patient/Guardian Name: _____ **Date:** _____