Welcome to The Glaucoma Center, P.C.

Alyson L. Hall, M.D.
Kevin C. Greenidge, M.D., MPH, FACS
Maria S. Servinsky, O.D.
Judy Hu, O.D.

The Glaucoma Center, P.C. is an ophthalmology practice devoted to comprehensive care of the glaucoma patient. Dr. Hall and Dr. Greenidge are fellowship-trained glaucoma specialist with a team of highly-trained staff that provide state-of-the-art comprehensive glaucoma care.

Glaucoma is an important, under-recognized problem and our goal is to provide early detection and intervention with safe, effective medications and/or advanced surgical techniques.

Your initial consultation may last up to two hours. As your eyes will be dilated in order to evaluate your optic nerve, you may wish to bring someone to drive you home. Sunglasses are also helpful to assist with glare.

The Glaucoma Center, P.C. participates with most insurance companies. If you are a member of a managed care program (HMO), you are responsible for obtaining a referral authorization from your primary care physician (PCP) for each office visit. The referral form must be given to our receptionist upon arrival, as well as your most recent insurance card and driver's license.

We have attached the necessary paperwork for your completion prior to your office visit. Bring this information with you on the first visit, as well as the following items:

1. A list of all your current medications
2. If you are currently taking eye drops, please bring the bottles with you.
3. Your current eyeglasses, even if you don't use them, or a copy of your eyeglass prescription.

Please do not hesitate to contact our office should you have any questions. We look forward to caring for you. In addition, please visit our website at ***glaucomacenter.net*** for more information and updates regarding our practice.

Rev. 12/19

PATIENT INFORMATION SHEET

PLEASE PRINT

WHOM MAY WE THANK FOR REFERRING YOU? _____

IF REFERRED BY ANOTHER DOCTOR, WHERE ARE THEY LOCATED? _____

PERSONAL INFORMATION

First Name: _____ **Middle Initial** _____ **Last Name:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Age:** _____ **Sex: M F** **Marital Status: S M W**

Home Phone #: _____ **Work #:** _____ **Cell #:** _____

Email Address: _____ **Retired: Y N**

Employer: _____

Primary Care Physician: _____ **Phone:** _____

Pharmacy: _____ **Phone:** _____

Location: _____

Person to Contact in Case of an Emergency: _____

Relationship: _____ **Phone:** _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____

Subscriber Name if other than patient: _____ DOB: _____

Secondary Insurance: _____ Policy #: _____

Subscriber Name if other than patient: _____ DOB: _____

INSURANCE ASSIGNMENT AND RELEASE

I authorize **The Glaucoma Center, P.C.** to apply for benefits on my behalf for services rendered. I request payment from my insurance company (companies) be made directly to **The Glaucoma Center, P.C.**

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, for this or any related claims.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing.

I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided when a statement is rendered. I realize that I am financially responsible for all services rendered to me by **The Glaucoma Center, P.C.**

X

Signature of Patient/Legal Guardian _____ Date _____

PATIENT'S REQUEST TO RESTRICT USE/DISCLOSURE OF PRIVATE HEALTH INFORMATION

I request that **The Glaucoma Center, P.C.** restrict the disclosure of my Private Health Information so that **ONLY** the family member(s), other relative(s) or close personal friend(s) herein names who is involved with my care or the payment of my care may have access to my Private Health Information:

Name of Individual/Relationship:

_____

_____

Signed: X _____ Date: _____

Witness: _____ Date: _____