The Glaucoma Center, P.C.

Alyson L Hall, M.D.
Pamela D'Souza-David, M.D.
Maria S. Servinsky, O.D.

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 # _____

E-Mail Address: _____ Retired: Y N

Employer: _____

Primary Care Physician: _____ Phone # _____

Pharmacy: _____ Phone # _____

Location: _____

Person to Contact in Case of 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.**

_____ _____

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 named 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: _____ **Date:** _____

Witness: _____ **Date:** _____