Glaucoma-Cataract Consultants, Inc.

Patient Name:______________________________________ Account #: ______________
Date of Birth: ________________________ Age: _______ SS#: ______________________
Address: ____
City: _________________________ State: _________________ Zip Code: _______________
Home Phone: ________________________ Work Phone: _____________________________

Marital Status: ______Single ______Married ______Divorced ______Widow

Legal Guardian (If applicable): ____

Person responsible if not patient: ___________________________Relationship: _____________
Address: ____
City: _________________________State: ____________ Zip Code: ____________________
Phone: ____

Occupation: ____
Employer: ____
Employer Address: ____
City: _________________________ State: ____________ Zip Code: ____________________
Employer Phone: ____

Primary Care Physician: ____
Optometrist: ____
Doctor who referred you to our practice: ____

Primary Insurance Company: ____
Address: ____
City: _________________________State: ____________ Zip Code: ____________________
Phone: ____
Identification # ____________________________ Group # ___________________________
Subscriber's Name: _________________________ Subscriber's Date of Birth: ______________

Secondary Insurance Company: ____
Address: ____
City: _________________________State: ____________ Zip Code: ____________________
Phone: ____
Identification # ____________________________ Group # ___________________________
Subscriber's Name: _________________________ Subscriber's Date of Birth: ______________

I have been informed of Glaucoma-Cataract Consultants, Inc.'s Privacy Practices and have had the opportunity to review these practices.

Sign ____ Date ______________