

**Arizona Glaucoma Specialists**

**Patient Registration**

Mr. Mrs. Miss Ms. Dr. : \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Alternate/Cell Phone: \_\_\_\_\_

Summer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status: \_\_Single \_\_Married \_\_Divorced \_\_Widowed

Referred to our office by: \_\_\_\_\_ M.D.\_ O.D.\_ D.O.\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ M.D.\_ O.D.\_ D.O.\_ Phone: \_\_\_\_\_

Patient's Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Patient's Spouse: \_\_\_\_\_ Work Phone: \_\_\_\_\_

In case of emergency please contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy Information: Name and Location: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Financially Responsible Party: \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PRIMARY INSURANCE NAME: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Subscriber, If other than patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Subscriber, If other than patient: \_\_\_\_\_ Subscriber DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please list other individuals who are authorized to discuss your health information:**

**I authorize the release of any medical information necessary to process all claims on my behalf.**

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**I authorize the release of payment for medical benefits to my physician.**

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_