GREENEYE GLAUCOMA Institute

Dear Patient, **Date** _____/_____/_____
Day Month Year

Thank you for this opportunity to meet your eye care needs in our friendly, professional environment. Our aim is to consistently exceed your expectations!

Name: Mr/ Miss/ Mrs. _____

Date of Birth: _____/_____/_____ **Age:** _____**years**
Day Month Year

P.O.Box: _____ **Address:**_____

Phone:_____**(Home)** _____**(Work)** _____**(Cell)**

Patient's Occupation: _____

Email: _____

Would you like for us to confirm your appointments by text message or email?_____

Emergency Contact:

Name: _____ **Relationship:**_____

Phone:_____**(Home)** _____**(Work)** _____**(Cell)**

How did you learn about GreenEye Glaucoma Institute?_____

Name of Health Insurance company: _____ **NIB#:** _____
(Please present card)

Please read and sign below:

Assignment of benefits: I authorize payment of benefits to supplier for services rendered. I understand that I am financially responsible for any balance not covered by my insurance.

Name: _____ **Signed:**_____

Date _____/_____/_____
Day Month Year