GLAUCOMA CENTER OF SAN FRANCISCO

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Emeritus
H. Dunbar Hoskins, Jr., M.D.
Robert N. Shaffer, M.D., *1912-2007*
John Hetherington, Jr., M.D., *1930-2020*

PATIENT REGISTRATION

PATIENT INFORMATION

Date: _____

Patient Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ Age: _____

Gender: _____ Race: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Preferred: ☐ Home ☐ Cell ☐ Work

E-Mail Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

Referred By: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ ☐ Mail Order Pharmacy

Address: _____

City, State: _____ Phone Number: _____

INSURANCE INFORMATION (please give insurance cards to receptionist to copy)

I certify that I (or my dependent) have insurance coverage as stated provided to the office. I authorize the release of any medical information necessary to process all claims and agree to have insurance payments made directly to Glaucoma Center of San Francisco to be applied to my account for services rendered. I understand that I am financially responsible for all charges incurred in the event that my insurance denies payment. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice. I am aware there may be additional collection and/or attorney's fees if my account is referred for collection.

_____ _____
Signature of Patient or Patient Representative Date