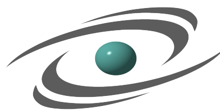

Maryland Glaucoma
and Eye Care

500 S Camp Meade Rd. Suite A
Linthicum Heights, MD 21090
443-354-1300

Name:____

Address:____
Street

____
City State Zip

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

D.O.B:_____/_____/_____ **Age:**__________ Single Married Divorced Widow/er

Occupation:____

Employer:____ **Phone:**(_____)_____-______

Address:____
Street State Zip

Emergency / Medical Contact:_______________________________________ **Phone:**(_____)_____-______

Emergency / Medical Contact:____ **Phone:**(_____)_____-______

Primary Care Doctor:______________________________________ **Phone:**(_____)_____-______

Referring Doctor:____ **Phone:**(_____)_____-______

Name of the Insurance Holder:____

Insurance Holder- D.O.B.:_____/_____/_____ **S.S. No.:**_____-_____-_____

If the Patient is a minor or someone other then the patient is responsible for the bill, please fill in the following information:

Name:____ **Phone:**(_____)_____-_____

Address:____
Street State Zip

I hereby authorize my insurance benefits to be paid directly to the undersigned or Salman Ali, MD. I am financially responsible for the uncovered payment. I also authorize release of any information required.

Signature:____ **Date:**_____/_____/_____