

PATIENT INFORMATION

PLEASE PRINT CLEARLY

LAST NAME	_____	FIRST:	_____	MI:	_____
STRT.ADDRESS	_____	CITY:	_____	STATE:	_____
SOC. SECURITY #	_____ - _____	HOME TEL:	(_____) _____		
DATE OF BIRTH:	____/____/____	WORK TEL:	(_____) _____		X
SEX	M F	SALUTATION:	MR. MRS. MS. MISS MASTER DOCTOR PROFESSOR REVEREND		
EMERGENCY CONTACT PERSON	NAME: _____				
(OTHER THAN HOME #)	PHONE: (_____) _____				
REFERRED BY:	_____				
	<input type="checkbox"/> DOCTOR	<input type="checkbox"/> FRIEND	<input type="checkbox"/> PHONEBOOK	<input type="checkbox"/> FAMILY MEMBER	<input type="checkbox"/> OTHER
MARITAL STATUS	_____				
	<input type="checkbox"/> MARRIED	<input type="checkbox"/> SINGLE	<input type="checkbox"/> DIVORCED	<input type="checkbox"/> WIDOWED	<input type="checkbox"/> OTHER

PARTY RESPONSIBLE FOR PAYMENT

LAST NAME	_____	FIRST:	_____	MI:	_____
STRT.ADDRESS	_____	CITY:	_____	STATE:	_____
	_____	HOME TEL:	(_____) _____		
SOC.SECURITY #	_____ - _____	WORK TEL:	(_____) _____		X
RELATIONSHIP TO PATIENT	<input type="checkbox"/> SELF	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> GRANDPARENT	<input type="checkbox"/> MOTHER	<input type="checkbox"/> OTHER
	<input type="checkbox"/> SON	<input type="checkbox"/> DAUGHTER	<input type="checkbox"/> GUARDIAN	<input type="checkbox"/> FATHER	
TX DRIVERS LICENSE #:	_____				
EMPLOYER:	_____				

INSURANCE INFORMATION

PRIMARY INSURANCE	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> TRADITIONAL INSURANCE
POLICY HOLDER 'S NAME:	_____
POLICY HOLDER'S DOB	_____
INS. CLAIMS ADDRESS:	_____
POLICY HOLDER'S PLACE OF EMPLOYMENT:	_____
PRIMARY CARE PHYSICIAN:	_____
	GROUP / POLICY # _____
	POLICY HOLDER ID# _____
	PCP PHONE # (_____) _____

SECONDARY INSURANCE	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> TRADITIONAL INSURANCE
POLICY HOLDER'S NAME:	_____
POLICY HOLDER'S DOB	_____
SEC. CLAIMS ADDRESS:	_____
POLICY HOLDER'S PLACE OF EMPLOYMENT:	_____
PRIMARY CARE PHYSICIAN:	_____
	GROUP / POLICY # _____
	POLICY HOLDER ID# _____
	PCP PHONE # (_____) _____

EyeCare Associates of Texas

1. Payments for office visits are due the day the services are rendered. In instances where we are filing your insurance, you will be asked to pay the co-payment/deductible at the time of service. We Accept Cash, Checks, VISA, MasterCard, Discover, and American Express for your convenience.

2. As a part of our service, we will submit insurance claims on your behalf, once you have provided us with the necessary information. You will be responsible for any unpaid office visits and/or procedures including refractions.

RELEASES

I hereby authorize *EyeCare Associates of Texas* to release any information requested by my Insurance company, admitting hospital and/or referring physicians, on behalf of my family or myself. I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I hereby assign payments received for medical services rendered to me and to my family to: *EyeCare Associates of Texas*.

I have been offered a copy of *EyeCare Associates of Texas'* Notice of Privacy Policies, detailing how my information may be used or disclosed as permitted under federal and state law. I understand the contents of the notice, and if I have any restrictions concerning the use of my personal medical information, I will inform *EyeCare Associates of Texas* in writing.

I hereby authorize *EyeCare Associates of Texas* to make complaints to the State Insurance Commissioner, the Health Care Financing Administration, or the Department of Labor on my behalf regarding my benefits claims.

CONSENT FOR TREATMENT OF MINORS: I, the undersigned parent or legal guardian of the above mentioned minor, authorize and consent to any necessary medical treatment including the administration of dilating eye drops if necessary. This authorization is valid for one year from the date signed.

Signed: _____ **Date:** _____