

Welcome to the Eye Clinics of South Texas. P.A.

To better serve you, please take a few minutes to fill out the following information

Date _____

Patient Information

Name _____
Last First Middle

Address _____
Street City State Zip

Phone # Home () - - Work () - -

Maiden Name _____ Date of Birth _____ Age (please) _____ Sex M F

SSN # - - Marital status: S M Other: Student Y N (If yes full or part time)

Driver's License # _____ Referred by _____

Employers name and address _____

Emergency contact and phone # _____

Insurance Information

Primary Insurance Company _____

Primary Insurance # _____ Group # _____

Insured _____ Insured's address _____

Phone # () - - DOB _____ Sex ; M F

Insured Employer _____

Relationship of patient to insured _____

Secondary Insurance Company _____

Secondary Insurance # _____ Group # _____

Insured _____ Insured's address _____

Phone # () - - DOB _____ Sex ; M F

Insured Employer _____

Relationship of patient to insured _____

Responsible Party (Fill out only if other than the patient)

Name _____
Last First Middle

Address _____
Street City State Zip

Date of Birth _____ Sex; M F Phone # () - -

SSN# - - Relationship to patient _____

Employer _____ Work # () - -

Payment policy

ALL SERVICES RENDERED ARE THE FINANCIAL RESPONSIBILITY OF THE PATIENT OR THE PATIENT'S PARENT OF GUARDIAN. THE PATIENT IS RESPONSIBLE FOR PAYMENT REGARDLESS OF INSURANCE COVERAGE. BILLING INFORMATION WILL BE PROVIDED TO EXPEDITE PATIENT REIMBURSEMENT FROM PRIVATE INSURANCE CARRIERS.

Authorization of payment

I HEREBY AUTHORIZE THE PROVIDER OF SERVICES TO RELEASE INFORMATION CONCERNING MY EXAMINATION AND /OR TREATMENT FOR INSURANCE PURPOSES AND TO RECEIVE DIRECT PAYMENT FOR BENEFITS PAYABLE TO ME FOR SERVICES RENDERED

SIGNED _____