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 ( ) - ________ -___________Cell ( ) -______- ____________

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 ______________ Email Address_________________________

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 # ( )- _______- ___________ Cell # ( ) -_____-_________

SSN# _________-_______ -___________ Relationship to patient ____________________ Email _________________________

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. BILLNG INFORMATION WILL BE PROVIDIED 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 ____