PATIENT INFORMATION

Account #__________________ Today's Date _______________

Name __________________ **Cell Phone** ______________ **Home Phone** ______________

Address __________________ **City** ______________ **Zip** ________ **Work Phone** ______________

Birth Date ________ **Social Security #** ______________ **Driver's License #** ______________ **Marital Status** ____

If Patient is under age 18, list Parent/Guardian and SS# __________________________________

Employer __________________________________ Employer Telephone ______________________

Spouse ______________________ Spouse's Social Security # ______________________________

Spouse's Employer ______________________________ Spouse's Business Telephone ________________

Who may we contact in case of an emergency? __________________________ **Phone** ________________

How did you choose our practice? ____

Referring Physician ________________ Phone ____________ Primary Care Physician ________________

Reason for Visit ____

Do you have an injury that you feel is employment related? ______________________________

Have you or any family members ever seen any of the doctors at Ophthalmology Associates? ______________

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List any medications to which you are allergic ____

New Patient Information Only **Insurance Information**

Primary Insurance ____________________ Policy Holder's Name & SS# ______________________________

Primary Ins. Policy # ________________ Primary Policy Group # ________________________________

Secondary Insurance __________________ Policy # and Holder ____________________________________

List any additional Insurance Carriers ____

Who is financially responsible for this bill? ____

I authorize this office to release any information necessary to expedite insurance claims and hereby assign medical benefit payments directly to Ophthalmology Associates of San Antonio. I understand that I am responsible for all charges, regardless of insurance coverage.

If I am the parent or guardian of the patient who is a minor or if I am authorized to act for a patient who is otherwise not competent to consent to treatment, I authorize treatment on the patient's behalf.

I understand that I may be given a return appointment in order to follow-up on my ocular status or condition. In the event that, for any or no reason, I do not keep that return appointment and do not promptly re-schedule, I agree not to hold Ophthalmology Associates of San Antonio, it's Physicians, and/or staff responsible for any resulting consequences. Appointments cancelled with less than 24 hours notice may be charged to your account.

Signature ____ **Date** ____________________

☐ **Self** ☐ **Parent or Guardian of Minor Child** ☐ **Acting on Behalf of Patient**