Account # _____ **PATIENT INFORMATION** Today's Date _____

Name _____ **Email** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Address _____ **City** _____ **State** _____ **Zip** _____

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

If Patient is under age 18, list Parent/Guardians name _____

SS# _____ **DOB** _____

Employer _____ Employer Telephone _____

Spouse _____ Spouse's Social Security # _____

Spouse's Employer _____ Spouse's Business Telephone _____

Who may we contact in case of an emergency? _____ **Relationship** _____ **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? _____

_____

List any medications to which you are allergic _____

Insurance Information Policy Holder's Name _____

Primary Insurance _____ Policy Holder's SS# & DOB _____

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 my 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 that 24 hours notice may be charged to your account.

Signature _____ **Date** _____

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