



PATIENT INFORMATION

Account # _____ Today's Date _____
Name _____ Email _____
Home Phone _____ Cell Phone _____ Work Phone _____
Address _____
City _____ State _____ Zip _____
Birth Date _____ Social Security # _____
Marital Status _____

If the Patient is under age 18, list Parent/Guardian's name _____
Social Security # _____ 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 _____

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 _____

PLEASE TAKE A MOMENT TO TELL US HOW YOU FOUND OUR PRACTICE:

Referring Doctor (First, Last Name)
 Insurance Company Practice Website
 Other (Please Explain): _____

Who is financially responsible for this bill?

I authorize this office to release my personal information which will be necessary to expedite insurance claims, and I hereby assign medical benefit payments 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, its Physicians, and/or staff responsible for any resulting consequences. Appointments cancelled with less than 24 hour's notice may be charged to your account.

Signature: _____ Date: _____

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