



PATIENT INFORMATION
Please print and provide complete information.

Legal First Name _____ MI _____ Legal Last Name _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell phone _____ Date of Birth _____ Age _____ Sex _____

Social Security # _____ Marital Status (Circle) S M W D Spouse's Name _____

If you have been seen here before, under what name? _____

Referred by _____ OD MD DO Phone _____

Address _____ City _____ State _____ Zip _____

Family Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Contact (other than spouse) _____

Relationship to patient _____ Phone _____

Employer _____ Address _____

City _____ State _____ Zip _____ Work Phone _____

Occupation _____

If Patient is a Minor or Dependent

Name of Responsible Party _____ Relationship to Patient _____

Responsible Party Address _____

City _____ State _____ Zip _____ Phone _____

PLEASE READ AND SIGN BELOW

I authorize the physicians and staff of Texas Retina Associates to perform procedures necessary to assess and diagnose my condition properly and to perform treatments as may be prescribed by my attending physician during any and all visits to Texas Retina Associates. I understand that I am financially responsible for ALL charges for services rendered to me by Texas Retina Associates.

Signature _____ Date _____

For office use only:

GMT ARL PL LUB COR SHER DEN WF PAR FW WA GR GL Physician _____

HIPAA Authorization: I authorize the following person(s) to discuss my medical care and billing/insurance information with the Texas Retina Associates staff on my behalf:

Name _____ Relationship _____

Name _____ Relationship _____

Primary Insurance Company _____

Claims Address _____

Phone _____ Group # _____ Subscriber ID# _____

Subscriber _____ Date of Birth _____ SS # _____

Relationship _____ Employer _____

Address _____ Phone _____

Secondary Insurance Company _____

Claims Address _____

Phone _____ Group # _____ Subscriber ID# _____

Subscriber _____ Date of Birth _____ SS # _____

Relationship _____ Employer _____

Address _____ Phone _____

Assignment of Benefits / Authorization to release information:

I hereby authorize Texas Retina Associates to release any information concerning my care for the purpose of claims to federal, state, city, or town governmental agencies, third party payors of all categories, doctors and hospitals.

I hereby authorize payment directly to Texas Retina Associates, the group hospital benefits or insurance benefits including Medicare, herein specified and otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to Texas Retina Associates for charges not covered by this authorization.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient _____ Date _____

-or-

Signature of Responsible Person _____ Date _____