

Account # _____ **PATIENT INFORMATION** 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? _____

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**