

Austin Eyecare

WELCOME TO OUR OFFICE PATIENT INFORMATION

Full name _____
Last First MI

Mailing Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Cell () _____

Email address _____
(We do not sell information, it is used in correspondence with this office only.)

Sex: M F Date of Birth ____/____/____ Social Security No. ____-____-____

Patient's Employer _____ Occupation _____

Patient's Primary Care Physician _____ Phone() _____

If patient is a minor, who has financial responsibility: _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____ Date of Birth _____

REFERRED BY

PLEASE INDICATE HOW YOU WERE REFERRED TO OUR OFFICE

I was referred by: Primary Care Physician _____
Another Eye Doctor _____
Family Member/Friend _____
Other _____

FAMILY MEMBERS/EMERGENCY CONTACTS

Who should we contact in case of an emergency? _____
Phone () _____

Please list another person to contact in case of an emergency who does not live with you.
_____ Phone () _____

PRIMARY INSURANCE COVERAGE

Name of Primary Insurance _____
Member # _____ Group # _____
Policy Holder's Name _____
Last First MI
Policy Holder's SS or ID No. ____ - ____ - ____ Date of Birth ____ / ____ / ____
Relationship to Patient _____ Employer _____
Work Phone () _____

SECONDARY INSURANCE COVERAGE

Name of Secondary Insurance _____
Member # _____ Group # _____
Policy Holder's Name _____
Last First MI
Policy Holder's SS or ID No. ____ - ____ - ____ Date of Birth ____ / ____ / ____
Relationship to Patient _____ Employer _____
Work Phone () _____

I give consent for treatment by the doctors of Austin Eyecare. I agree and understand that my eye(s) may be dilated in order for the doctor to thoroughly check the retina of the eye. I agree and understand that my eye(s) may need to be patched as part of treatment for my condition. I understand that if my pupils are dilated and/or my eye is patched that I may not be able to safely operate a motor vehicle and that the staff and doctors of Austin Eyecare request and strongly urge that I arrange alternate transportation.

Payment is due at the time services are rendered. My insurance company will be filed on my behalf by the staff of Austin Eyecare. I authorize any holder of my medical information to release such information to any agency necessary to determine benefits payable, compliance or utilization. I authorize and direct my insurance carrier(s) to issue payment for services rendered to Austin EyeCare. Benefits are determined by the contract between you, as the covered member, and your insurance company. I understand that payment for services are ultimately my responsibility and I agree to pay all incurred charges in full immediately upon receipt of a statement from the practice of Austin Eyecare.

I have read and understand the financial policy of the practice, and I agree to be bound by the terms. I also understand and agree that the practice may amend such terms from time to time.

Thank you!

Patient's Signature or Parent's Signature if minor _____

HIPAA COMPLIANCE ACKNOWLEDGEMENT OF RECEIPT

I understand the HIPAA Compliance laws of Austin Eyecare and a copy shall be provided at my request.

Signature _____ Date _____