

RETINA CONSULTANTS OF HOUSTON

6560 Fannin Street, Suite 750
Houston, TX 77030

PATIENT INFORMATION

Patient's *Legal* Name: _____
Date of Today's Visit: _____ Social Security Number: _____
Date of Birth: _____ Age: _____ Sex: M F Marital Status: S M D W
Street Address: _____
Mailing Address: _____
City, State, Zip: _____
Home phone: _____ Cell: _____ Work: _____
Name of Spouse: _____ Emergency Contact Name and Number: _____
Name of Referring Physician: _____ Phone # of Referring Physician: _____
Date of Last Exam with Referring Physician: _____
Name of Primary Care Physician: _____ Phone # Of Primary Care Physician: _____
Occupation: _____ Is this a work related injury? _____
Employer: _____
Employer Address: _____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ ID # _____ Group # _____
Insured's Name: _____ Relationship to Patient ___Self ___Spouse ___Dependent
Insured's Employer: _____ Phone: _____
Employer's Address: _____
Insured's Social Security Number: _____ Date of Birth: _____ Sex ___M ___F

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ ID # _____ Group # _____
Insured's Name: _____ Relationship to Patient ___Self ___Spouse ___Dependent
Insured's Employer: _____ Phone: _____
Employer's Address: _____
Insured's Social Security Number: _____ Date of Birth: _____ Sex ___M ___F

I hereby assign, transfer, and set over Retina Consultants of Houston all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of my medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: _____ Date: _____