

VITREORETINAL CONSULTANTS
6560 FANNIN ST. STE. 750
HOUSTON, TX 77030

PATIENT INFORMATION

Patient's *Legal* Name _____
Date of Today's Visit: _____ Social Security # _____
Date of Birth: _____ Age: _____ Sex: M F Marital Status: S M W D
Address: (Street) _____
(City, State, Zip) _____
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 Co.: _____ ID # _____ Group # _____
Insured's Name: _____ Relationship to Patient ___Self ___Spouse ___Dependent
Insured's Employer: _____ Phone# _____
Employer's Address: _____
Insured's Social Security # _____ Date of Birth _____ Sex ___M ___F

SECONDARY INSURANCE INFORMATION

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

I hereby assign, transfer, and set over Vitreoretinal Consultants all 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: _____