

WELCOME TO EAST TEXAS EYE CENTER, P.A.
PATIENT REGISTRATION

Mr. Mrs. Ms. Miss

Patient Name _____ Social Security # _____
Age _____ DOB _____ Sex: **M** **F** Marital Status: Single Married Divorced Widowed
Address: _____
City _____ State _____ Zip _____
Phone: Home _____ Work _____ Cell _____
Employer _____ Student: Part-time _____ Full-time _____ Non-Student _____
Primary Care Doctor (PCP) _____ PCP Phone # _____
Emergency Contact Person: _____ Phone # _____

New Patients: HOW DID YOU HEAR ABOUT OUR OFFICE: TV Insurance Drive-by Yellow Pages Mailer
Relative/Friend _____ Doctor _____ Other _____

IF PATIENT IS A MINOR: Please print the parent/guardian's name.

Parent/Guardian Name: _____ DOB _____
Address: _____ Relationship to patient _____
Phone: Home _____ Work _____ Cell _____

INSURANCE INFORMATION

PRIMARY Insurance _____ Policy # _____ Group# _____
POLICY HOLDER: Name _____ SS # _____ DOB _____
Relationship to patient: _____ Employer _____

SECONDARY Insurance _____ Policy # _____ Group# _____
POLICY HOLDER: Name _____ SS # _____ DOB _____
Relationship to patient: _____ Employer _____

VISION Insurance _____ Policy # _____ Group# _____
POLICY HOLDER: Name _____ SS # _____ DOB _____
Relationship to patient: _____ Employer _____

If no insurance, are you responsible for your fees? Yes _____ NO _____
If not, who is? Name _____ Relationship to patient _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing below, I am acknowledging that I have been provided with a copy of East Texas Eye Center, P.A. Privacy Notice pursuant to the Federal Regulations known as the HIPPA Privacy Rule.

Signature _____ Date _____
Print Name _____ Relationship to Patient _____

Or Parent/Guardian if patient is a minor

FINANCIAL ASSIGNMENT AND AGREEMENT

I authorize all insurance benefits to be paid directly to East Texas Eye Center, P.A., and agree to be financially responsible for any remaining balance (deductible, co-insurance, refractions, eyeglasses, contact lenses or any other balance not paid by the insurance). I also authorize East Texas Eye Center, P.A. to release information regarding myself and my medical treatment to insurance companies, hospitals, surgery centers, and physicians as deemed professionally necessary for treatment and to process my insurance claims.

Signature _____ Date _____
Print Name _____ Relationship to Patient _____

Or Parent/Guardian if patient is a minor

