AUSTIN RETINA ASSOCIATES PATIENT INFORMATION

NAME: _____
Last First Middle Initial

MAILING ADDRESS or NURSING HOME NAME & ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____ -

TELEPHONE: HOME / CELL/ WORK ( ) _____ **EMAIL :** _____

DATE OF BIRTH: _____ / _____ / _____ **AGE:** _____ **RACE:** _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED **GENDER: MALE FEMALE**

DRIVERS LICENSE # _____ **STATE:** _____ **SS#:** _____

EMPLOYER: _____ **OCCUPATION:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

SPOUSE / PARENT / GUARDIAN NAME: _____ **EMPLOYER:** _____
Circle One:

EMERGENCY CONTACT: _____ **PHONE:( )** _____ **CELL: ( )** _____

MEDICARE #: _____ **MEDICAID #:** _____

HEALTH INSURANCE NAME: _____

INSURED NAME: _____ **INSURED DATE OF BIRTH:** _____ / _____ / _____

INSURED ID#: _____ **GROUP #:** _____ **RELATIONSHIP TO PATIENT:** _____

OTHER HEALTH INSURANCE NAME: _____

INSURED NAME: _____ **INSURED DATE OF BIRTH:** _____ / _____ / _____

INSURED ID#: _____ **GROUP #:** _____ **RELATIONSHIP TO PATIENT:** _____

REFERRING PHYSICIAN NAME: (first) _____ **(last)** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PRIMARY CARE PHYSICIAN NAME: (first) _____ **(last)** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

I authorize any and all insurance benefits, to which I am entitled for services rendered by Austin Retina Associates, to be paid directly to Austin Retina Asscociates. I agree it is my responsibility to pay charges not covered by my insurance. I authorize any holder of medical or other information about me to release to the Social Security Administration, HCFA, and its subsidiaries, and other insurance carriers or health care providers, any information needed for this or a related Medicare or other insurance claim. I permit a copy of this authorization to be used in place of the original. This authorization is in effect until I choose to revoke it.

SIGNATURE:_____ **DATE:**_____/_____/_____