_____New Patient _____Update _____Dr._____ Patient#_____

Thank you for choosing Eye Centers of Southeast Texas, L.L.P.
Please complete the following - filling in all spaces that apply.

Referred by (Person/Doctor):_____ **Name of Primary Care Physician**_____

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial	Birth Date	Age	Sex	Marital Status

Mailing Address	City	State	Zip

S.S. Number	Home Phone	Cell Phone	Work Phone	Occupation

Employer	Employer Address

Spouse's Name	Birthday	Work Phone	Cell Phone

Nearest Local Relative or Friend (Not Living With You)	Their Phone Number

GUARANTOR INFORMATION (Person responsible for Payment)

Guarantor Name (Last, First, Middle Initial)	Birth Date	S.S. #	Occupation

Mailing Address (Include City, State, Zip)	Home Phone	Work Phone

INSURANCE INFORMATION

Primary Insurance Company	ID#	Group #

Primary Insurance Card Holder's Name	Subscriber's S.S.#	Birthdate	Relationship to Patient

Secondary Insurance Company	ID#	Group #

Secondary Insurance Card Holder's Name	Subscriber's S.S.#	Birthdate	Relationship to Patient

Have you ever been seen by a physician of Eye Centers of Southeast Texas? _____No ____Yes - _____Years Ago

I understand that I am responsible for the $35.00 refraction charge if it is not covered by my insurance.
AUTHORIZATION FOR MEDICAL TREATMENT: I consent to and authorize the administration and performance of treatments and procedures which in the judgement of the physician may be necessary or advisable for myself or my dependent.
ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION: I hereby authorize and request my insurance company to pay directly to the doctor the amount due on my claim for services rendered. I further agree that should the amount be insufficient to cover the entire medical expense, I will be responsible for payment of the difference. If the service is not covered by the policy, I will be responsible for payment of the entire bill. I also authorize release of any medical information necessary to process my claim. This release allows information to be released for utilization management and financial audits.
ELIGIBILITY WAIVER: I will receive services today with the understanding that in the event my coverage is not effective or if this physician is not allowed according to my insurance plan, I will be billed and be held financially responsible for all services rendered.

_____ _____
Patient or Responsible Person's Signature Date