

PATIENT INFORMATION

Account# _____

When registering. Please present proof of insurance, Medicare and/or Medicaid.
PAYMENT IS EXPECTED AT TIME OF SERVICE.

PATIENT INFORMATION

NAME _____
Mailing Address _____
City _____ Zip _____
Phone: Hm: () _____
Cell: () _____
Date of Birth _____ Age _____
SS# _____ Gender _____
Drivers License # _____ State _____
Circle one Single Married Divorced Widowed

INSURANCE (Check One)

Medicaid _____
Medicare _____
Blue Cross/Blue Shield _____
Policy Holder _____
Policy Holders D.O.B. _____

PATIENT'S EMPLOYER

Employer _____
Address _____ City _____ Zip _____
Phone () _____
Occupation _____

Referred by: _____

PATIENT'S SPOUSE/GUARDIAN

NAME _____
Address _____
City & Zip _____
Phone () _____
Relationship _____
Employer _____

RESPONSIBLE PARTY (other than patient)

NAME _____
SS# _____
Address _____
City & Zip _____
Employer _____
Address _____
City & Zip _____
Phone () _____

IN CASE OF EMERGENCY:

NAME _____
Address _____
City & Zip _____
Phone () _____

I certify the above information is correct to the best of my knowledge, I also understand that I am financially responsible for all charges whether or not covered by insurance.

I also acknowledge that a copy of NOTICE OF PRIVACY POLICIES AND PRACTICES was given to me at this time.

Signature _____

Date _____

MEDICAL HISTORY

	<u>Circle One</u>	
1. Have you ever had any severe eye injuries?.....	yes	no
2. Have you ever had eye surgery?.....	yes	no
3. Do you have any allergies?.....	yes	no
4. Do you have any medical illnesses?.....	yes	no
<u>Circle all that apply:</u>		
Diabetes		
High Blood Pressure		
Thyroid Problems		
Cancer		
Arthritis		
5. Do you take any medications?.....	yes	no
6. Has anybody in you family ever:		
had eye surgery?.....	yes	no
had Blindness?.....	yes	no
had Glaucoma?.....	yes	no
had Cataracts.?.....	yes	no
had Retinal Problems?.....	yes	no
had Diabetes?.....	yes	no

BLANKET ASSIGNMENT

DATE: _____

Note: In order to have us bill your insurance(Medicare, Medicaid or any other insurance) you must sign this release.

"I _____
request that payment of authorized Medicare benefits, or other insurance benefits, be made on my behalf for my lifetime to **DR. ALFREDO TREVINO JR/DR. ROBERTO RAMOS** for any services furnished to me by that physician. I authorize any holder of medical information about me to be released it to the HEALTH CARE FINANCING ADMINISTRATION and its agents, or any Insurance company, any information needed to determine these benefits or the benefits payable for related services.

I _____ patient of **DR. ALFREDO TREVINO JR./DR. ROBERTO RAMOS** accept responsibility for payment for services rendered that are not covered by Medicare, Medicaid, Government Agencies or Private Insurance.

Print Patient Name _____

SIGNATURE _____
(patient, parent, or legal guardian)