

**PATIENT INFORMATION FORM**

**Please print and provide complete information for each item**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F

Marital Status: \_\_\_\_\_ Social Security #: \_\_\_\_\_ E-mail: \_\_\_\_\_

If you have been seen here, under what name and what year were you last seen: \_\_\_\_\_

Referred By: \_\_\_\_\_ Family Physician/PCP: \_\_\_\_\_

**EMPLOYER INFORMATION:**

Employer's Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Telephone: \_\_\_\_\_

**RESPONSIBLE PARTY:**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employers Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**EMERGENCY CONTACT NAME:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact's Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**MEDICARE and/or MEDICAID:**

Medicare Number: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

**PRIMARY INSURANCE:**

Insurance Company: \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Group number: \_\_\_\_\_ Policy number: \_\_\_\_\_

Policyholder's Employer and Address: \_\_\_\_\_

**SUPPLEMENTAL INSURANCE INFORMATION:**

Insurance Company: \_\_\_\_\_ Name of Policyholder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Group number: \_\_\_\_\_ Policy number: \_\_\_\_\_

Policyholder's Employer and Address: \_\_\_\_\_

**LAB SERVICES**

I understand that I may receive a separate bill if my personal medical care includes lab, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not covered by my insurance for whatever reason.

**CONSENT TO TREATMENT**

I hereby authorize the physicians and staff of Cornea Associates of Texas to perform procedures necessary to assess, diagnose and treat my condition as necessary.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_

**GUARANTOR SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_  
(If different from patient)

**GUARANTOR NAME: (Please Print)** \_\_\_\_\_