

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Widowed

Race:  African American  Asian Pacific  Caucasian  Hispanic  Native American  Other: \_\_\_\_\_

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

Employer's Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**MEDICAL INFORMATION**

List all allergies to medication/latex/adhesives: \_\_\_\_\_

Primary Care Physician Name \_\_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

Date of Last Eye Exam \_\_\_\_\_ Name of Previous Eye Care Provider \_\_\_\_\_

Diabetes/Year diagnosed \_\_\_\_\_  Insulin  Oral Medication \_\_\_\_\_  Diet-Controlled

Glaucoma  Lung Problems  Bleeding Problems  Heart Problems  Stomach/Bowel Problems

Kidney Problems  Liver Problems  HIV Positive  Use Plaquenil  Prolonged use of Steroids

Use Tobacco  Use Alcohol  Other Serious Medical Problem \_\_\_\_\_

Reason for today's visit:

Cataract Evaluation  Routine Eye Exam  Surgery to reduce your dependency on glasses/contacts

Other: \_\_\_\_\_

**HOW WERE YOU REFERRED TO US**

Friend/Family/Acquaintance, Name: \_\_\_\_\_

Were you referred by a doctor? Name: \_\_\_\_\_

Specialty \_\_\_\_\_ Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_ Phone # \_\_\_\_\_

TV, Channel \_\_\_\_\_  Radio, Station \_\_\_\_\_  Magazine \_\_\_\_\_  Internet  Paper

Other: \_\_\_\_\_

PLEASE TURN OVER AND COMPLETE THE BACK OF THIS FORM

**PRIMARY HEALTH INSURANCE INFORMATION**

Insurance Co \_\_\_\_\_

Address \_\_\_\_\_

ID \_\_\_\_\_ Group \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to patient: Self Spouse Parent**SECONDARY HEALTH INSURANCE INFORMATION**

Insurance Co \_\_\_\_\_

Address \_\_\_\_\_

ID \_\_\_\_\_ Group \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB \_\_\_\_\_

Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Relationship to patient: Self Spouse Parent**Attention Medicare Patients:**

Medicare patients are responsible for their deductible and the 20% copayment that Medicare does not pay. If you have met any portion of your yearly \$135 deductible, please bring a copy of your Medicare EOMB which shows how much you have met. You may also be responsible for a \$40 refraction fee that is usually never covered by Medicare or any other insurance.

**Attention All Patients:**

Payment is due at the time of service.

Method of payment: Cash Check Credit Card: MC/Visa/AMEX/Discover

I understand that I am responsible for my bill even in the event my insurance denies my claim. I request payment of authorized insurance benefits be made on my behalf to the Key-Whitman Eye Center and the Key-Whitman Surgery Center for any services furnished to me. I further request that supplemental insurance benefits filed on my behalf be paid as stated above. I authorize direct payments by insurance companies to my physicians, and the ASC facility and I release any information acquired in the course of my examination or treatment to those insurance companies. I authorize any holder of medical information about me to release to any insurance company and its agents any information needed to determine these benefits payable for related services. I authorize release of my medical records to my primary care physician.

I have been given the opportunity to read the "Patient Information Privacy Notice" for the Key-Whitman Eye Center and the Key-Whitman Surgery Center.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Notice concerning complaints:**

Complaints about physicians as well as other licensees and registrants of the Texas State Board of Medical Examiners, including physician assistants and acupuncturists, may be reported for investigation at the following address: Texas State Board of Medical Examiners, Attention: Investigations, 1812 Centre Creek Dr., Suite 300, P.O. Box 149134, Austin, TX 78714-9134, 1-800-201-9353.

Complaints regarding Key-Whitman Surgery Center may be registered with the Department of State Health Services Facility Licensing Group, 1100 West 49<sup>th</sup> St., Austin, TX 78756, 1-888-973-0022.

**Thank you for choosing Key-Whitman Eye Center & Key-Whitman Surgery Center today!**