Glaucoma Associates of Texas

Patient Information Sheet

Patient's Name	Nickname	Referring Physician	
Address			
City/State	Zip	Phone No. ( )	Phone No. (Day) ( )

Sex (circle one) Male Female	Birth Date	S.S. #	Patient's Employer	Occupation

Employer's Address	Zip	Phone No. ( )

Marital Status (circle one) Single Married Widowed Divorced	Age	Spouse's Name	Spouse's Employer

Notify in case of emergency	Address (street, city, state)	Phone No. ( )
Notify in case of emergency (Not in household)	Address (street, city, state)	Phone No. ( )

Dou have Medicare? (circle one) Yes No	Medicare Number	Do you have Medicaid? (circle one) Yes No	Medicaid Number

Do you have Texas Commission for the Blind? (circle one) Yes No	Counselor Name & City

Do you have Champus? (circle one) Yes No	If so, name of insured	Policy No.	S.S. #	Status (circle one) Active Retired Deceased

Do you have HMO or PPO? (circle one) Yes No	If so, name of company	Is pre-approval required? (circle one) Yes No

Address (street, city, state)	Zip	Contact Person	Phone No. ( )

Name of Insurance Company (Private)	Policy No.	Is pre-approval required? (circle one) Yes No

Name if insured	Date of Birth of Insured	S.S. #	Patient's relationship to insured
Address (street, city state, zip)			

Name of Insurance Company (secondary)	Person to contact	Pre-approval required? (circle one) Yes No

Name of insured	Patient's relationship to insured

Address (street, city, state, zip)			
Is this a Worker's Compensation Claim? (circle one) Yes No	Date of Injury	Contact person	Phone No. ( )

I hereby authorize the Physician's at GLAUCOMA ASSOCIATES OF TEXAS to perform such treatments to me as may be prescribed by any attending physician during any and all of my visits to GLAUCOMA ASSOCIATES OF TEXAS.

I understand that I am financially responsible for ALL charges arising from services rendered to me by GLAUCOMA ASSOCIATES OF TEXAS.

Patient's Signature: ____ Date: _____________________

I AUTHORIZE GLAUCOMA ASSOCIATES OF TEXAS TO FILE ON ANY AND ALL INSURANCE FOR ANY CHARGES THAT I INCUR. I REQUEST THAT ALL PAYMENTS FROM ANY OF THESE INSURANCES TO BE MAILED DIRECTLY TO GLAUCOMA ASSOCIATES OF TEXAS. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND IT'S AGENTS, OR INSURANCE COMPANY, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

Patient's Signature: ____ Date: _____________________

IT IS THE POLICY OF OUR OFFICE NOT TO TREAT MINORS WITHOUT THE CONSENT OF A PARENT OR LEGAL GUARDIAN. IF A WRITTEN ONE CANNOT BE OBTAINED, A PHONE CONSENT WILL BE REQUIRED.

Patient's Signature: ____ Date: _____________________