Treviño Eye Clinic & Optical

PATIENT INFORMATION FORM

When registering please present proof of insurance, Medicare and/or Medicaid.

PATIENT INFORMATION

NAME _____

Mailing Address _____

City _____ **Zip** _____

Phone: Hm: ( ) _____

Cell: ( ) _____

Date of Birth _____ **Age** _____

SS# _____ **Gender** _____

E-MAIL: _____

Marital Status: **Single** **Married** **Divorced** **Widowed**

INSURANCE (Check One)

Medicaid _____

Medicare _____

Insurance Carrier _____

Policy Holder _____

Policy Holders D.O.B. _____

PATIENT'S EMPLOYER

Employer _____

Address _____

City _____ **Zip** _____

Phone ( ) _____

Occupation _____

Referred by: _____

PATIENT'S SPOUSE/GUARDIAN

NAME _____

DOB _____

SS# _____

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 _____

Relationship _____

Phone ( ) _____

( ) _____

I certify that 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 PRACTICES* and a copy of Trevino Eye Clinic's *ADMINISTRATIVE & FINANCIAL POLICIES* were given to me at this time.

SIGNATURE _____ **DATE** _____

MEDICAL HISTORY

Circle One

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

Circle all that apply:
Diabetes
High Blood Pressure
Thyroid Problems
Cancer
Arthritis
High Cholesterol
Other:_____

5.Do you take any medications?..... …… yes no

6.Has anybody in you family ever had:

Eye Surgery?..... yes no
Blindness?..... yes no
Glaucoma?..... yes no
Cataracts?..... yes no
Retinal Problems such as Retinal Detachment?..... yes no
Diabetes?..... yes no
Macular Degeneration?...……. yes no
Other eye-related problems _____

Information Authorization

Please write the name(s) of the persons to whom we may release your **MEDICAL, FINANCIAL**, or **PERSONAL** information to:

NAME	RELATION TO PATIENT	PHONE #
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that all of the above medical information is correct to the best of my knowledge and authorize the release of my information to the individual(s) written above.

Print Patient Name _____

SIGNATURE _____ **DATE** _____
(patient, parent, or legal guardian)