

Ophthalmology Specialists of Texas, PLLC.
West Texas Retina Consultants/ North Texas Retina Consultants

PATIENT INFORMATION SHEET

First Name: _____ MI: ____ Last Name: _____ Today's Date: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Patient's Date of Birth: _____ Age: _____ Sex: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Marital Status: _____ Social Security Number: _____

Race: _____ Language: _____ E-mail: _____

Receive appointment reminders via: **EMAIL** **TEXT** **PHONE CALL** (You can select up to 3)

Employed: **Y** **N** (if yes) Full time Part time Self Retired Military Occupation: _____

PRIMARY INSURANCE INFORMATION: Commercial Medicaid Medicare Self Pay

Insurance Company: _____ ID#: _____ GROUP#: _____

Insured's Full Name: _____ **DOB:** _____ **SSN#:** _____

Relationship to Patient: Self ____ Spouse ____ Child ____

SECONDARY INSURANCE INFORMATION: **PLEASE NOTE WE DO NOT ACCEPT RETRO ACTIVE MEDICAID**

Insured's Full Name: _____ **DOB:** _____ **SSN#:** _____

Relationship to Patient: Self ____ Spouse ____ Child ____

Preferred Pharmacy: _____ **Town:** _____ **Phone #:** _____

Emergency Contact Name: _____ **Relationship:** _____

Phone Number: _____ Address: _____

REFERRED BY:

FAMILY PHYSICIAN:

Name: _____ City: _____ Physician's Name: _____ City: _____

PLEASE READ AND SIGN BELOW

I hereby authorize the physician and staff of Ophthalmology Specialists of Texas to perform procedures necessary to assess and diagnose my condition properly and such treatments as may be prescribed by my attending physicians during any and all visits to OST, I understand that I am financially responsible for ALL charges arising from services rendered to me by OST.

Signature: _____ Date: _____

VUELTA PARA EL ESPANOL

OST Doctor _____

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RELEASE OF INFORMATION:

I hereby authorize Ophthalmology Specialists of Texas to release any information concerning my care for purpose of claims to Federal, State, City, or Town Governmental Agencies, third party payers of all categories, doctors, and hospitals.

I permit a copy of this authorization to be in place of the original.

Signature of Patient: _____ Date: _____

OR

Signature of Other
Responsible Person: _____ Date: _____

ASSIGNMENT OF BENEFITS:

I hereby agree to pay the established charges for services and all other charges incurred as a patient of Ophthalmology Specialists of Texas.

I further hereby authorize payment directly to OST, the group Hospital Benefits or Insurance Benefits, including Medicare, herein specified otherwise payable to me, but not to exceed the regular charges for this period of admission. I understand that I am financially responsible to OST for changes not covered by this authorization.

I will cooperate in seeking, collecting, and paying to OST, any and all insurance proceeds. If the insurance proceeds cannot be paid directly to OST, I agree to collect payment and pay to OST with in five (5) days of receipt. Unless prior arrangements have been made regarding payment to Ophthalmology Specialists of Texas.

I permit a copy of this authorization to be used in place of the original.

Signature of Patient: _____ Date: _____

OR

Signature of Other
Responsible Person: _____ Date: _____

The Following names are of people I would like to be involved in or have access to my protected health information on a routine basis. I give permission for Ophthalmology Specialists of Texas to share my protected health information with (not including other doctor offices):

Name Relationship/Phone No.

Name Relationship/Phone No.

Name Relationship/Phone No.

Name Relationship/Phone No.