CHILDREN'S EYE CENTER
of South Texas, P.A.

Patient Demographics

Please fill out all information

Patient's Name:_____ Nickname:_____

Date of Birth:_____ Age:_____ Grade: _____ Sex:_____

Address:_____
Number and Street City State Zip Code

Primary Contact #: (____)_____ Patient's Social Security **#**:_____

Parent/Guarantor Name:_____ Work/Alternate Phone #:_____

Email Address:_____

Emergency Contact: Name:_____ Phone #:_____

List of other persons allowed access to patient's medical eye information (step-parents, grandparents, siblings, caretaker, etc..)

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient Referred By: Name:_____ Phone:_____

Address:_____

Please list any other physicians that may require a letter for your visit with us:

Name:_____ Number:_____

Name:_____ Number:_____

Insurance Coverage: Name of Insurance Company:_____
(ID CARD REQUIRED)
Name of Policy Holder:_____ Relationship:_____ Date of Birth:_____

Work/Alternate Phone #:_____ Social Security #:_____

Name of Secondary Ins. Company:_____

Name of Policy Holder:_____ Relationship:_____ Date of Birth:_____

Work/Alternate Phone #:_____ Social Security #:_____

Refraction Fee:

A Refraction test determines whether or not your child needs glasses, and how strong they should be. Some insurance companies cover this test, but most do not. If your insurance does not cover the refraction fee, you will be responsible for this portion of the bill in addition to your co-payment.

I have read and understand the above information. _____
Initials

To the best of my knowledge, the above information is correct, and I hereby authorize **Children's Eye Center of South Texas, PA** to release medical information to my insurance company. I authorize payment of surgical and/or medical benefits directly to **Children's Eye Center of South Texas, PA.** I understand that I am financially responsible for all charges not covered by this authorization, and I hereby guarantee payment of this account to 1314 E. Sonterra Blvd, Suite 5201, San Antonio, TX 78258. I authorize release of all medical records requested by **Children's Eye Center of South Texas, PA.**

_____ _____
Signature Date