Internal Use:
❑ NP
❑ Established
❑ SM ❑ K ❑ W

CENTRAL TEXAS EYE CENTER

Patient's Name:_____ _____
(last) (first) (middle) (Preferred Name)

Mailing Address:_____
(street) (city, state) (zip)

Phone Numbers: Home:_____ **Cell:**_____ **Work:**_____

Email Address_____ **Patient's Social Security #:**_____

Age:_____ **Birthdate:**_____ **Sex:**_____ **Driver's License #** _____

Patient's Status: ❑ Single ❑ Married ❑ Widowed ❑ Student **Spouse Name:**_____

Emergency Contact: _____ **Emergency Phone:**_____

Responsible Party (if other than above)

Name:_____ **Relation to Patient?**_____

Address:_____ **Telephone**_____

How Did You Hear About Us? (Check All That Apply)
❑ I'm a Previous Patient ❑ Doctor Referral ❑ Yelp ❑ Facebook
❑ Patient or Family ❑ Our Website ❑ Google ❑ Health Fair
❑ Chamber of Commerce ❑ Your Insurance ❑ Other: Please Specify_____

Appointment Confirmation Preference: (Must choose one)
❑ Phone Call ❑ Text Message ❑ Email

Insurance Information: Please allow receptionist to photocopy your insurance card.

Insurance Company Name: _____

Policy#: _____ **Group#:** _____

Insurance Subscriber's Name: _____ **SS#:**_____

Medicare and many private insurance carriers do not cover the refraction (the test to determine the power for eyeglasses and best corrected vision) You are responsible for this charge plus any insurance deductibles and/or co-payments. All payments and co-payments are due on the day of service.

Signature:_____ **Date:**_____