South Texas Eye Center

4406 N. Laurent, Victoria, Texas 77901 | Phone: 1-800-352-5928

Patient Registration Form (Please fill out all areas and then print using the button at the end)

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Name (last) (first) (M.I.) Age DOB (M / D / Y) Sex

Address City State Zip

Work (Daytime) Phone Number Home (or other) Phone Number Social Security # Patient's Employer (or school)

	Name	Employer	Daytime Phone	Date of Birth	SS#
Father or Guardian				MM/DD/YYYY	
Mother				MM/DD/YYYY	

Emergency Contact Daytime Phone Relationship to Patient

Was condition related to employment? Y N (If yes, please ask receptionist for an accident form to complete)

Auto Accident? Y N Other accident? Y N

Who were you referred by: ☐Phone Book ☐Yellow Pages ☐Newspaper Ad ☐TV/Radio

☐Friend ☐Relative ☐Physician / Physician's name:

INSURANCE AND BILLING INFORMATION

Medicare Number Medicaid Number

Primary Insurance

PolicyHolder's Name MM/DD/YYYY Date of Birth SSN

Address (if different from Above) City State Zip

PolicyHolder's Employer Location Phone

Patient's relationship to insured ☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance

PolicyHolder's Name MM/DD/YYYY Date of Birth SSN

Address (if different from Above) City State Zip

PolicyHolder's Employer Location Phone

Patient's relationship to insured ☐Self ☐Spouse ☐Child ☐Other

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

By my signature, I hereby authorize SoutTexas Eye Center to examine, treat, and perform diagnostic tests and office procedures that the physician deems necessary. I hereby allow South Texas Eye Center to furnish any information pertaining to my medical treatment to my insurance carrier, worke compensation representative, attorney, employer, or other providers of service. I agree that all payments made by my insurance will be to South Texas Eye Center. I understand I am ultimately responsible for any balance on my account.

PRINT THIS FORM!

Signed Date