Alamo City Eye Physicians, P.A.
Patient Information (Please Print)

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: ____
(Last) (First) (MI)

Patient's Social Security # _____ Ethnicity or Race: _____

Address: _____
Number, street name, and apartment # city state zip

Home phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Occupation: _____ Employer/ School: _____

Email Address: _____

Spouse's or Parent's Name: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Endocrinologist: (If Diabetic) _____ Phone #: _____

Who should we contact in an emergency?: _____ Phone #: _____
Name Relationship

Referred by: _____ Phone #: _____

Has any member of your family ever been treated at this office? □ YES □ NO

INSURANCE INFORMATION Insurance Company: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Member ID #: _____ Group #: _____

Medicare #: _____ Medicaid #: _____

Secondary Insurance: _____ Seconday Policy #: _____

__ PPO __ HMO __ Worker's Comp
__ DARS : Counselor's Name: _____

IMPORTANT INFORMATION REGARDING PAYMENT, INSURANCE BENEFITS, AND REFRACTIONS

Payment of services rendered are due and payable in full at the time of service unless other arrangements have been made in advance. **There is a $25 NO-SHOW fee for any missed appointments not cancelled at least 24hrs in advance of appointment time.**

I request Alamo City Eye Physicians, P.A. and staff to perform those tasks necessary for my medical care and to apply any insurance benefits to my account. I realize that any administrative work being performed is on a courtesy basis and that I am responsible for payment of any services not covered by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

REFRACTIONS

Refraction is the process of determining the need for corrective lenses. It is part of an eye exam, but is NOT a covered service by Medicare, most managed care plans, or private insurances. **Our office fee for refraction is $50.00.** The refraction fee is in addition to a patient's copay. I understand that refraction is typically a non-covered service and I accept full financial responsibility for the cost of the refraction.

_____
Patient's Signature (Parent for Minor) Date