Registration : **Fort Worth Eye Associates**

Date	Account ID	Chart ID	Other ID	Internal Use

Patient Information

Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Age	Social Security #

Address	Home Phone Work Phone Cell Phone	How did you hear of us?
Address 2	Email:	

City	State	Zip Code	Employer Name & Address	Occupation

Emergency Contact	Phone	Pharmacy	Phone

Pref Language:	**Race:**	**Ethnicity:**	**County:**

Provider	**Family Physician**	**Referring Physician**

Medical Insurance	**Name & Address**	**Policyholder**	**Relationship**	**Copay**	**Policy ID**	**Group ID**
1						
2						
3						

Policyholders/Guarantors (Person to be billed, if different than patient)

1 Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work Phone	Email:

City	State	Zip Code	Employer Name & Address	Occupation

2. Last Name	First Name	Middle	Gender	Marital Status	Birthdate	Social Security #

Address	Home:	Work Phone	Email:

City	State	Zip Code	Employer Name & Address	Occupation

HIPAA Approved Contacts

1. Last Name	First Name	Middle	Gender	Birthdate	Social Security #	Relationship

Address	City	State	Zip Code	Home:	Cell:	Work Phone

Are you currently enrolled in Nursing Facility or Hospice? Yes___ No___
If Yes, please list the facility name/address_____

Would you prefer to receive your appointment reminder via text message? Yes___ No___

Patient's or Authorized Person's Signature

I the undersigned give my authorization to treat and assign directly to Fort Worth Eye Associates **,** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am ultimately financially responsible for all approved and covered charges whether or not paid 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 my insurance submissions. I understand that payment is expected at the time of service.

I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me, and conducting healthcare operations.

Signature	**Signature Date**	**Fort Worth Eye Associates**
X		5000 Collinwood Ave Fort Worth, TX 76107 Phone: 817-732-5593 Email:

Please attach all pertinent insurance ID cards for photocopying.