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 Name: ____________________ **Emergency Phone Number:** ______________________

Responsible Party (if other than patient)

Name: _________________________________ **How Related to Patient?** ___________________________

Address: _______________________________________ **Telephone** ________________________________

Have any members of your family been seen in our office before? ______________________________________

How Did You Hear About Us? (Check All That Apply)

❑ I'm a Previous Patient ❑ Doctor Referral ❑ Google ❑ Facebook
❑ Patient or Friend Referred ❑ Our Website ❑ Yelp ❑ Health Fair
❑ Chamber of Commerce ❑ 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#** ____________________________
(if not the patient)

Medicare and many private insurance carriers do not cover the refraction (a 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-pays are due on the day of service.

Signature: ____ **Date:** __________________