DIETLEIN EYE & LASER CENTER

311 Riverbend Drive * Georgetown, TX 78628* 512-931-2255* Fax 512-819-9528

Patient Name: (Mr. Mrs. Ms. Miss) _____

Primary phone # ( )_____ Alternate phone # ( )_____

Address: _____
Street City State Zip code

Sex: Male / Female Marital Status: Single Married Divorced Widowed Separated

Social Security: _____-_____-_____ Driver's License #: _____

Date of Birth: _____ Age: _____ Email Address: _____

Employer: _____ Phone ( )_____
Address: _____

Primary Care Physician: _____ Phone ( )_____

Spouse/Parent Name: _____ Phone ( )_____
Employer: _____ Phone ( )_____

How did you hear about our office? _____

FINANCIALLY RESPONSIBLE PERSON

Name:_____Relationship:_____SSN:_____
Address: _____
Primary phone # ( )_____ Alternate phone # ( ) _____

I understand that I am responsible for paying the amount billed to me for services rendered.

Signature: X_____ Date: _____

INSURANCE INFORMATION

******HEALTH INSURANCE INFORMATION AND SIGNATURES ARE REQUIRED FOR SUBMISSION******

Primary Insurance Company: _____
Address: _____ Phone ( )_____
Policy/Subscriber ID#_____ Group #: _____
Name of Policy Holder:_____ SSN: _____
Policy Holder Date of Birth: _____ Relationship to Patient: _____

Secondary Insurance Company:_____
Address: _____ Phone ( )_____
Policy/Subscriber ID#_____ Group #: _____
Name of Policy Holder: _____ SSN:_____
Policy Holder Date of Birth: _____ Relationship to Patient:_____

Does insurance require a second opinion? Yes or No Prior Authorization? Yes or No

I authorize the release of any medical information necessary to process claims. I also request payment of government or other benefits to myself or to the party who accepts assignment.

Signature: _____

I authorize payment of medical benefits to my physician or supplier for service.

Date: _____

Signature: _____