El Paso Eye Surgeons, P.A.
1201 North Mesa Suite C
El Paso, Texas 79902

New Patient Information

PERSONAL INFORMATION (Please Print)

Name _____ Date _____

Date of Birth _____ Age _____ M / F _____ Soc Security # _____

Address _____
Street City State Zip

Phone: Home (___) _____ Work (___) _____

Occupation _____ Employer _____

Address _____ Phone (___) _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name _____ Employer _____

Address _____ Phone (___) _____

Complete if under 18 years or a student

Name of Father _____ Employer _____

Address _____ Phone (___) _____

Name of Mother _____ Employer _____

Address _____ Phone (___) _____

Referred by: Doctor _____ Friend/Relative _____
Name Name

Other _____

INSURANCE INFORMATION

☐ Medicare # _____ ☐ Medicaid # _____

☐ Workers Compensation (job injury) to whom is bill to be sent? _____

☐ Other Medical Insurance _____

Group # _____ ID# _____

Name/Address 2nd Insurance _____

Are you personally responsible for the payment of your fees? ☐ Yes ☐ No If not, who is?

Name _____ Relationship _____ DOB _____

Who to notify in emergency (nearest relative or friend)?

Name _____ Relationship _____

Address _____
Street City State Zip

Home Phone (___) _____ Work Phone (___) _____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to thedoctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**
2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare.**
3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits or the benefits payable for related services.
4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signed (Patient or parent if minor) _____ Date _____