

Howerton Eye Clinic, PLLC

2610 South IH35
Austin, TX 78704
(512) 443-9715

PATIENT INFORMATION

NAME (Last, First Middle)			MRN	SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		REFERRING PHYSICIAN		SECONDARY/BILLING ADDRESS (if Applicable)	
HOME PHONE	DAY PHONE	EMAIL ADDRESS		PRIMARY CARE PROVIDER		CITY, STATE ZIP	
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME		CONTACT PHONE	HOME PHONE
PRIMARY EMPLOYER				SECONDARY EMPLOYER (if Applicable)			
ADDRESS				ADDRESS			
CITY, STATE ZIP				CITY, STATE ZIP			
WORK PHONE				WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)			SSN#	BIRTHDATE	LANGUAGE	SEX
LOCAL ADDRESS		CITY, STATE ZIP		SECONDARY/BILLING ADDRESS (if Applicable)		
HOME PHONE	DAY PHONE	EMAIL ADDRESS		CITY, STATE ZIP		
MARITAL STATUS	STUDENT STATUS <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE	
RELATIONSHIP TO PATIENT						

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			POLICY#		
NAME OF INSURED			GROUP#		
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$		
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY			POLICY#		
NAME OF INSURED			GROUP#		
ADDRESS OF INSURANCE COMPANY			COPAY AMT \$		
CITY, STATE ZIP		PHONE	DEDUCTIBLE \$		
RELATIONSHIP TO PATIENT			EFFECTIVE DATE	EXPIRATION DATE	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor 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. I hereby authorize said assignee to release all information necessary to secure the payment. We request that your charges for the office visit be paid at the conclusion of each visit unless you are covered by Medicare. I request that payment of authorized Medicare and insurance benefits be made on my behalf for any services furnished me. I understand that I am financially responsible for all charges whether or not paid by said insurance. A credit of \$25.00 or under will not be refunded, it will be added as a credit to the patient account.

SIGNATURE OF PATIENT/GUARDIAN

DATE