

DIETLEIN & LABBE EYE ASSOCIATES

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.

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

Date: _____

Signature: _____

Signature: _____