GLAUCOMA CENTER OF TEXAS

Patient Information Sheet

First Name:	**Middle Initial:**	**Last Name:**	
Date of Birth:	**Age:**	**Gender:**	**Marital Status:**
Social Security #:	**Email Address:**		
Mailing Address:	**City:**	**State:**	**ZIP:**
Home Phone:	**Cell Phone:**		

Appointment Reminder Contact Preference *(circle one option)*:

Voice Call **Text Message** **Email**

Are you interested in our patient portal for records/communication?

Referring Doctor:	**Primary Care Physician:**

EMPLOYER INFORMATION:

Patient's Employer:	**Occupation:**
Employer's Address:	**Phone:**

EMERGENCY CONTACT:

Name:	**Relationship to Patient:**
Home Phone:	**Cell Phone:**

IF PATIENT IS A MINOR OR DEPENDENT

Name of Responsible Party:	**Relationship to Patient:**
Address:	**Phone:**

PHARMACY INFORMATION:

Pharmacy Name:	**Pharmacy Phone Number:**
Pharmacy Address, City, State, Zip Code:	

OVER →

PRIMARY INSURANCE (Complete with information about this policy/policy holder only):

Insurance Company Name:	**Name of Policy Holder:**	**Policy Holder Date of Birth:**
Address:		**Phone:**
Group Number:	**Policy Number:**	**Employer Name:**
Employer Address:		

SUPPLEMENTAL INSURANCE (Complete with information about this policy/policy holder)

Insurance Company Name:	**Name of Policy Holder:**	**Date of Birth:**
Address:		**Phone:**
Group Number:	**Policy Number:**	**Employer Name:**
Employer Address:		

PLEASE READ AND SIGN BELOW

I authorize the physicians and staff of Glaucoma Center of Texas to perform procedures necessary to assess and diagnose my condition and to perform treatments as may be prescribed by my attending physician during any and all visits to Glaucoma Center of Texas.

I understand that I am financially responsible for all charges arising from services rendered to me by Glaucoma Center of Texas.

I hereby authorize Glaucoma Center of Texas to furnish information to insurance carriers concerning my illness and treatments. I authorize Glaucoma Center of Texas to file on any and all insurance for any charges that I incur. I request that all payments from any of these insurances be mailed directly to Glaucoma Center of Texas.

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Patient's Signature (*or Authorized Representative/Guardian*) **Date**