T, O (id #2607, dob: 01/01/2000)

T, O 01/01/00 #2607

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Please review and update the information below to the best of your ability.

Patient Registration

CURRENT PATIENT INFORMATION -- PLEASE PRINT	Guarantor Information (to whom statements are sent)
Last Name: **T**	Name: **O T**
First Name: **O**	Address:
Middle Name:	**SAN ANTONIO, TX 78213**
Address:	Relationship to patient: _____
City: **SAN ANTONIO** State: **TX**	Date of Birth: **01/01/2000**
Zip: **78213**	Social Security No.:
Home Phone: **(210) 348-8788**	Phone: ( ) _____ - _____
Work Phone:	**Emergency Contact Information**
Mobile Phone:	Name:
Sex: **F**	Relationship:
Date of Birth: **01/01/2000**	Phone:
Social Security No.:	Mobile Phone:( ) _____ - _____
Patient email:	
Required by government mandate [although you may refuse]:	**Employer information**
Language: **Patient Declined**	Employer:
Race: **Patient Declined**	Address:
Ethnicity: **Patient Declined**	Phone:
Marital Status:	

Other	Pharmacy Information:
Patient Referred by:	With whom may we share your healthcare information?
Primary Care Provider:	Name: _____
Contact Preference: Home Phone / Work Phone / Mobile Phone / Portal / Email	Relationship: _____
	Phone Number: _____

Primary Insurance Information	Secondary Insurance Information
Insurance Plan Name: ***SELF PAY***	Insurance Plan Name:
Last Name:	Last Name:
First Name:	First Name.:
Middle Name:	Middle Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Date of Birth: Sex (please circle): **M** or **F**	Date of Birth: Sex (please circle): **M** or **F**
Employer Name:	Employer Name:
Patient's relationship to policy holder:	Patient's relationship to policy holder:

To the best of my knowledge the above information is complete and accurate.

Signed_____ **Date:**_____

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Please sign and date each item below

ACKNOWLEDGEMENT AND AUTHORIZATION:

- **I have read and understand the HIPAA/Privacy Policy for CASTLE HILL EYE SPECIALISTS PA**

Signed_____ **Date:**_____

- **I hereby assign my insurance benefits to be paid directly to the healthcare provider**

Signed_____ **Date:**_____

- **I authorize CASTLE HILL EYE SPECIALISTS PA to release medical information required to process my claim**

Signed_____ **Date:**_____

- **I have read and understand the Financial Policy for CASTLE HILL EYE SPECIALISTS PA**

Signed_____ **Date:**_____

- **I authorize CASTLE HILL EYE SPECIALISTS PA to obtain/have access to my medication history**

Signed_____ **Date:**_____

- **I authorize my provider's office to contact me by mobile phone**

Signed_____ **Date:**_____