

Patient information Form

Calvin E. Mein, MD

Moises A. Chica, MD

9480 Huebner
San Antonio, TX 78240

Suite 310
(210) 615-1311

Welcome to our office! The following information is used for our records and for insurance purposes. Please be as accurate as possible. Thank you for your cooperation.

Today's Date: _____

Patient Name: _____
(Last) (First) (Middle)

MALE _____ FEMALE _____

Date of Birth: _____ Social Security Number: _____

Child Single Married Divorced Widowed

Mailing Address: _____ City: _____ State: _____
(Number & Street) Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Employer: _____ Work Phone: (____) _____

Spouse/Parent Name: _____ Contact Number: (____) _____

Spouse/Parent Employer: _____ Contact Number: (____) _____

Family Physician: _____ Phone: (____) _____

Who should we contact in an emergency? _____ Phone: (____) _____

Referred By: Doctor: _____ Phone: (____) _____

Other: _____ Phone: (____) _____

Insurance Information

Name of Primary Insurance Company: _____

Secondary Insurance Company: _____

Insured Name: _____ Social Security # _____

Insured's Date of Birth: _____
Month Day Year

Relationship to the Patient: () Spouse () Mother () Father () Other: _____

() Medicare # _____ () Medicaid # _____

() Workers Comp () DARS Counselor's Name: _____ Phone # _____

Insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment to the doctor. Some companies pay fixed allowances for certain procedures, and others pay as 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.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and other health plans to Retinal Consultants of San Antonio, P.A.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as a 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.

Responsible party:

X _____

Date: _____ / _____ / _____
Month Day Year

****You will be dilated today. After your exam your vision may be blurry. Please do not drive while your eyes are dilated. We recommend someone drive you home. There is a phone in the waiting area for you to call for a ride.**