CENTRAL TEXAS
RETINA INSTITUTE

Patient Information Form

(Please Print)

Patient Name:		Age:	Date of Birth:
Email:			Sex: ☐ Male ☐ Female
Home Phone:	Cell Phone:		Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Address:			
City:	State:	Zip:	

Check One: ☐ White ☐ African American ☐ Hispanic/Latino
☐ Asian/Native Hawaiian/Pacific Islander ☐ American Indian/Eskimo/Aleut
☐ Other _____

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Social Security #:	Driver's License #:	
Employer:	Occupation:	Work Phone:
Family Physician:	Physician Phone:	
Spouse/Parent Name:	Spouse/Parent Birthdate:	
Spouse/Parent Phone:	Spouse/Parent Employer:	
Emergency Contact:	Phone:	

Referral Information:

Doctor Name: _____ Office Phone: _____ Specialty: _____

I authorize the Physician and Staff to perform those tasks necessary for medical care. I understand I may be given a return appointment to follow up on my ocular condition. I will not hold the Physician and/or staff responsible for any resulting consequences due to my failure to keep these appointments.

I certify that the above information is correct, and I understand that I am responsible for any co-payments, deductibles, or non-covered items at the time services are rendered. I authorize the Physician to release all information necessary to my insurance company to secure the payment of benefits.

Please check your communication preference: ☐ Email ☐Cell Phone ☐Home phone ☐Text

No show policy received ☐ Yes ☐ No

Patient's Signature: _____ Date:_____

1100 North Main Avenue, San Antonio, Texas 78212
Phone: (210) 880-3000 Fax: (210) 227-6056

Updated: April 25th, 2025