



**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

Patient's Signature: _____

Date: _____

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