Retina Associates of South Texas, P.A.
Lina M. Marouf, M.D. • Timothy P. Cleland, M.D., M.S.E.
Juan E. Rubio Jr., M.D. • Enchun M Liu, M.D.

PATIENT INFORMATION:

NAME: ______________________ D.O.B.: ______________ AGE: ________ SEX: ___

ADDRESS (Street): ____

CITY: ______________________ STATE: ______________ ZIP: ______________

SOC. SEC. #: ______________________ PHONE #: ______________ MARITAL STATUS: ______

E-MAIL: ____

PATIENT'S EMPLOYER: ______________________ PHONE #: ______________

SPOUSE'S NAME: ______________________ WORK #: ______________

SPOUSE'S EMPLOYER ADDRESS: ____

IN CASE OF EMERGENCY CONTACT: ______________________ PHONE #: ______________

REFERRED BY (PHYSICIAN): ____

PRIMARY CARE PHYSICIAN: ____

OTHER SOURCE: ____

PLEASE COMPLETE BACK SIDE

IS THIS VISIT DUE TO AN ACCIDENT? YES________ NO_________

IS THIS WORK RELATED? YES_________ NO__________
DATE OF INJURY:_________________

IS THIS AN AUTOMOBILE ACCIDENT? YES________ NO___________
DATE OF ACCIDENT:________________

IF PATIENT IS A MINOR OR STUDENT:

MOTHER'S NAME:_________________________HOME #:________________WORK #:______________
ADDRESS (City, State, Zip):____
FATHER'S NAME:_________________________HOME #:________________WORK #:______________
ADDRESS (City, State, Zip):____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize the physician indicated above to furnish information to insurance carriers concerning this illness/accident, and I hereby irrevocably assign to the doctor all payments for medical and or surgical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

In order to control our cost of billing, we request that office visits be paid at the time service is rendered. We would rather control our billing costs than be forced to raise our fees.

SIGNATURE OF PATIENT OR GUARDIAN:____________________________________ DATE:______________