WRIGHT
EYE CARE CENTER

4185 Technology Forest Blvd., Ste. 225 ▪ The Woodlands, TX 77381
P: **936-297-2030** ▪ F: **832-442-9847**
wrighteye2020.com

PATIENT INFORMATION

Date: _____ Gender: _____ Age: _____

Last Name: _____ Birthdate: _____

First Name/MI: _____ Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Minor

Title: ❑ Miss ❑ Mrs ❑ Mr. ❑ Dr. Employment Status: _____

Address: _____ Employer: _____
(Parents Employer)

City: _____ Occupation: _____

State: _____ Zip: _____ Referred by: _____

Home Ph# _____ Cell # _____ Email: _____

INSURANCE POLICIES

Vision insurance is used for routine eye exams for glasses or contact lenses and includes VSP, Superior Eyemed, and Spectera. However, it does not cover medically related findings or complaints.

Medical insurance will cover medical findings or complaints such as dryness, redness, itch, burn, eye pain, floaters, headaches, glaucoma, cataracts, macular degeneration and more.

Vision Insurance: _____ ID# _____ Group# _____

Primary Medical Insurance: _____ ID# _____ Group# _____

Secondary Medical Insurance: _____ ID# _____ Group# _____

GUARANTOR (POLICY HOLDER) ❑ Self ❑ Spouse ❑ Parent

(If you are the patient and the Primary on the insurance you do not need to complete this portion.)

Last Name: _____ First Name/MI: _____ Suffix: _____

Gender: _____ DOB: _____ SSN: _____

Address: _____ Home Phone: _____

City: _____ Cell Phone: _____

State: _____ Zip: _____ Employer: _____

ASSIGNMENT OF BENEFITS AUTHORIZATION

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor or ophthalmic group insurance benefits otherwise payable to me - I understand that my eyecare insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf and that of my dependents.

CONSENT FOR TREATMENT

I hereby authorize Wright Eye Care Center to examine and treat me, or, the individual for whom I am responsible. During the course of exam, dilation drops may be used to dilate the pupils. These drops may cause temporary blurred vision and glare.

X _____

SIGNATURE OF PATIENT *(Or parent if minor)* DATE