LONG VISION CENTER

PLEASE FILL OUT THE ENTIRE FORM.

How did you hear about our office? Doctor referral Friend/family Internet search Other

Patient Name:_____ **Date of Birth**_____

Address:_____ **City**_____ **State**___ **Zip**_____

Home #_____ **Cell#**_____ **SS#**_____

Employed:_____ **Work #**_____ **May we call there?**_____

Email:_____ **Marital Status: S M D W Spouse:**_____

Emergency Contact_____ **Phone#**_____ **Relationship:**_____

Pharmacy_____ **City**_____ **Phone#**_____

Primary Care Physician:_____ **Phone#**_____

Employment Status	**Student Status**	**Race**	
(Please circle one)	**(Please circle one)**	**(Please circle one)**	
Full time	Full time	American Indian	Hispanic/Latino
Part time	Part time	Asian	Pacific Islander
Retired	Non student	African American	Caucasian
Not working			

Insurance Information – Write SELF only if you are the primary insurance member

Name of Insured:_____ **DOB:**_____ **Relationship to patient:**_____

Mailing Address:_____ **City**_____ **State**___ **Zip**_____

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Assignment of Benefits: I hereby assign all medical benefits from my health plan to Texoma Eye Associates. This assignment will remain in effect until revoked by me in writing. I authorize Texoma Eye Associates to release all information necessary and required to process my insurance claim.

Medicare DMEPOS Supplier Standards: The products provided to you by Texoma Eye Associates are subject to the supplier standards contained at 42 Code of Federal Regulations Section 424.57 ©. The full text of these standards can be obtained at http://ecfr.gpoaccess.gov.

Signature of Patient:_____ **Date:**_____

Or if patient is a minor

Signature of Guardian:_____ **Date:**_____