ALAMO EYE INSTITUTE, P.A.
LYNNELL C. LOWRY, M.D.

OPHTHALMOLOGY / OPHTHALMIC SURGERY

Thank you for selecting our heathcare team! We will strive to provide you with the best possible heath care. To help us meet all your healthcare needs, please fill out his form completely in ink. If you have any questions or need assistance, please ask us, we will be happy to help.

DATE: _____

Patient Information

Name _____ Male _____ Female _____

Birthdate: _____ Age: _____ Social Security # _____

Address: _____ Minor __ Single __ Married __ Widowed __ Separated __

City: _____ State: _____ Zip: _____

Home phone: _____ Work #: _____ Ext. _____ Mobile #: _____

Where do your prefer to receive calls? ___ Home ___ Work ___ Cell

When is the best time to reach you? Time _____ Days _____

Employer _____ Occupation _____

Referred by: First Name: _____ Last Name: _____ MI: _____

Who is responsible for the account?

Name _____ Relationship to patient _____

Birthdate _____ Driver's License # _____

Social Security Number _____

Address _____

City, State, Zip _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

PRIMARY INSURANCE

Name of Insured _____ Insured's birthdate _____ Soc. Sec. # _____

Employer _____ Insurance Co. _____

Group # _____ Employee/Cert. # _____

SECONDARY INSURANCE _____ ID# _____

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

I understand that my 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 or my dependents.

X _____

Signature of patient or parent if minor

Financial Arrangements: For your convenience, we offer the following methods of payment. Please check the option you prefer: Payment is expected in full each visit. ❑ cash ❑ personal check ❑ credit card