Patient Information

Date_____

Name_____Birthdate_____

Address_____

City_____State_____Zip_____

Phone_____Alt. Phone_____E-Mail_____
(needed to send you your retinal photos)

Male_____ Female_____ Age_____

Person responsible for account (if not patient)_____Phone_____

Name of emergency contact?_____Relationship_____ Phone_____

Insurance Information

Insurance Company_____ID#_____Group#_____

Patient Social Security #_____Patient Employed by_____

Single_____ Married_____ Widowed_____

(Complete next section if the patient is not the primary member of above insurance)

Primary Member _____Social Security #_____Birthdate_____

Relationship to Patient_____Phone_____Employer_____

Authorization To Pay Benefits To Provider

I hereby authorize payment directly to all providers of the medical benefits, if any; otherwise payable by me for services rendered by Dr. Reed. I understand that I am responsible for any charges incurred by me or any party for whom I am legally responsible.

I, the undersigned, hereby acknowledge that it is the policy of this office that full payment be made at each visit and I am responsible for payment to Dr. Jason Reed for all services rendered to the above patient that are not covered by third party insurance.

Patient/Guardian Signature_____Date_____

Release Of Medical Records and Information

To: Custodian of Medical Records

This authorized you to release to Jason Reed, OD, 9300 S. I-35 Ste C-100, Austin, TX 78748 full and complete medical records, reports, evaluations, consultations or information (collectively referred to as "medical records") you may have in custody concerning the undersigned patient. The undersigned represents and warrants that he/she has full authority to request said records

Patient/Guardian Signature_____Date_____

Acknowledgment of Privacy Policy

I acknowledge that I have viewed and been offered a copy of the privacy policy for Jason Reed, OD.

Patient/Guardian Signature_____Date_____

Retinal Photos

Retinal photos provide an accurate means to document and monitor the health of the eyes. With a more complete view of the whole retina, eye diseases may be diagnosed and treated more effectively. Retinal photos allow the doctor to see the effects of diabetes, high blood pressure, cataracts, retinal tears or holes, as well as many other diseases. There is an additional charge of **$15.00** for photos.

_____Yes, I would like retinal photos _____No, I would not like retinal photos

Visual Fields Screening

Visual field testing is performed in order that the doctor may assess the function of the central and peripheral (side) vision. With this computerized test the quality of the entire visual field is assessed very accurately. Visual field testing helps the doctor evaluate glaucoma, diabetes, macular degeneration, brain tumors, as well as many other diseases. There is an additional charge of **$15.00** for a visual field screening.

_____Yes, I would like a visual field screening _____No, I would not like a visual field screening