Cataract, Glaucoma & Retina
CONSULTANTS OF EAST TEXAS
Medical Arts Surgery Center | Benchmark Optical

Welcome! Please present all insurance and vision cards with your driver's license to receptionist!

*If your insurance requires a REFERRAL, present it to our receptionist at check-in, **OR**: have your PCP fax it to 936-564-3770*

Please bring a list of all of your current medications to each visit!

How were you referred to us?

Family / Friends / Our patient(s) / Newspaper / Radio / TV / Doctor____________________ / Other ____________________

Patient Name: First:______________________________ Last:____________________________________ Middle Initial:______

Mailing Address: Street:___________________________________City:______________________State:_____Zip:__ ________

Home Phone:__________________________ Work Phone:_____________________Cell Phone: _________________________

Email Address:____Primary Method of contact: Home / Work / Cell / Email

Social Security #:_____________________Date of Birth:_____________Sex: Male / Female Occupation:__________________

Race: African American / Asian / Caucasian / Hispanic / Middle Eastern / Pacific Islander / Other:_________________

Marital Status: Married / Single / Divorced / Separated / Widowed

Spouse Name:_______________________________Date of Birth:_______________Social Security#:_____________________

Spouse Phone:______________________Emergency Contact:_________________________Phone:_____________________

Medicare Primary Ins. ID #:_______________________________**OR** Primary Insurance: _________________________________

Policy #: ____ Group #: ____

Primary Ins Policy Owner:____________________Date of Birth:_______________Social Security#: _____________________

Secondary Insurance: ________________________Policy #_________________________Group # _____________________

Secondary Ins Policy Owner:__________________Date of Birth: ________________Social Security#: ____________________

Thank You

We respectfully require that all co-payments, deductibles and self-pay balances be paid at the time of your appointment

I have read, completed and agree to all of the above: Signature: ______________________________ Date: _____________