LAWRENCE A. WRIGHT, M.D., F.A.C.S.
DISEASES AND SURGERY OF THE EYE
3100 Timmons Ln., Ste 150 • Houston, TX 77027 • Tel: (713) 529-1955

Date_____ REFERRED BY :_____

PATIENT_____
First M.I. Last

SEX: M F DATE OF BIRTH_____AGE_____MARITAL STATUS: S M D W

HOME PHONE: _____OFFICE PHONE: _____CELL PHONE_____

HOME ADDRESS: _____
Street

_____
City State Zip Code

SPOUSE'S NAME_____CONTACT PHONE_____

PATIENT'S EMPLOYER: _____

BUSINESS ADDRESS_____
Street City State Zip Code

OCCUPATION: _____

PATIENT'S SOCIAL SECURITY NUMBER: _____

IF MINOR OR FULL-TIME STUDENT:

MOTHER'S NAME: _____CONTACT PHONE:_____

FATHER'S NAME_____CONTACT PHONE: _____

IN CASE OF EMERGENCY:

NAME: _____RELATIONSHIP:_____

CONTACT PHONE_____

FAMILY PHISICIAN: _____PHONE:_____

PHARMACY: _____PHONE:_____

INSURANCE:
PLEASE PROVIDE INSURANCE CARD TO BE COPIED:_____

ACKNOWLEDGMENT
I understand that I am financially responsible for all charges for services rendered to me, including any deductibles, co-pays, non-covered services (including refractions) or coinsurance balances remaining after insurance payment. I authorize the release of payment from my insurance for services rendered to Lawrence A. Wright, M.D. I also authorize the release of any medical information necessary to process insurance claims.

Patient's signature (or parent if minor) Date