PATIENT INFORMATION

PATIENT NAME _____ BIRTH DATE _____ M ❑ F ❑
First M Last

PATIENT ADDRESS _____
Street City State Zip

MAILING _____ OTHER FAMILY MEMBERS SEEN _____
(If different) Please list

HOME PHONE _____ CELL PHONE _____

PARENT / LEGAL GUARDIAN INFORMATION

PARENT _____ DOB __/__/____

_____
address if different from patient

HOME PHONE _____

EMPLOYER _____

BUSINESS PHONE _____

EMAIL _____

PARENT _____ DOB __/__/____

_____
address if different from patient

HOME PHONE _____

EMPLOYER _____

BUSINESS PHONE _____

EMAIL _____

DOCTOR/PEDIATRICIAN _____
name address phone

PATIENT REFERRED BY _____
name address phone

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE CO. _____

SUBSCRIBER _____

ID # _____ GRP _____

MEDICAL _____ VISION _____ COPAY _____

SECONDARY INSURANCE

INSURANCE CO. _____

SUBSCRIBER _____

ID # _____ GRP _____

MEDICAL _____ VISION _____ COPAY _____

ASSIGNMENT FOR INSURANCE BENEFITS AND PAYMENT AGREEMENT

I hereby authorize Child Eye Care Associates, L.L.C. to release to my insurance company any information acquired in the course of my/my child's examination or treatment and permit payment directly to Child Eye Care Associates, L.L.C. for benefits due me for services. I am personally responsible for any balance due on my account, whether or not paid for by insurance. If my insurance company requires a referral for this visit or future visits and one is not obtained, I will be responsible for any charges incurred. It is understood and agreed that should Child Eye Care Associates, L.L.C. be required to undertake legal action to recover payments for my medical services I am responsible for all collection, legal and court costs incurred in that effort.

_____
Signature *Date* *Relationship to patient*