OPHTHALMOLOGY ASSOCIATES, P.S.C.
PATIENT INFORMATION
PEDIATRIC

DATE_____________ ACCT #____________
DR #______________
NAME: LAST__________________________FIRST____________________MID INIT_____
ADDRESS____
CITY___________________________STATE _____________ZIP_________________
BIRTH DATE________ Sex: (M/F_____ AGE____HOME PHONE________________________
PEDIATRICIAN_______________________________SSN:_____________________________
EMAIL ADDRESS ____
Person with whom we may share your medical and financial records:____________________
RELATIONSHIP________________________

BILLING INFORMATION
PARENT OR GUARDIAN

FATHER
NAME: LAST__________________________FIRST____________________MID INIT_____
ADDRESS____
CITY_____________________STATE___________________ZIP________________
SSN:_____________________HOME PHONE__________________CELL_______________
EMPLOYER__________________________________WORK PHONE___________________

MOTHER
NAME: LAST__________________________FIRST____________________MID INIT_____
ADDRESS____
CITY_____________________STATE___________________ZIP________________
SSN:_____________________HOME PHONE__________________CELL_______________
EMPLOYER__________________________________WORK PHONE___________________

ALTERNATE CONTACT______________________PHONE NUMBER_________________

PRIMARY INSURANCE ____
SUBSCRIBERS NAME______________________________________DOB________________
POLICY NUMBER_________________________GROUP NUMBER_____________________
SECONDARY INSURANCE____
SUBSCRIBERS NAME______________________________________DOB________________
POLICY NUMBER_________________________GROUP NUMBER_____________________

IF YOUR INSURANCE COMPANY REQUIRES A REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN FOR YOU TO BE SEEN BY A SPECIALIST, IT IS YOUR RESPONSIBILITY TO OBTAIN THE REFERRAL.

AUTHORIZATION: I HEREBY AUTHORIZE THE PHYSICIAN INDICATED ABOVE TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING THE ILLNESS/ACCIDENT. I HEREBY IRREVOCABLY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE.

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DATE RESPONSIBLE PARTY SIGNATURE