

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 FOR PATIENT PORTAL _____
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 _____

PHARMACY NAME _____ PHONE NUMBER _____
ADDRESS _____ ZIP CODE _____

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.

DATE

RESPONSIBLE PARTY SIGNATURE