Pediatric Ophthalmology, P.A. and the Center for Adult Strabismus—Minor

8222 Douglas Ave. #400 Dallas, TX 214-369-6434 1631 Lancaster Dr. #200 Grapevine, TX 817-329-5433
6000 W. Spring Creek Parkway #130, Plano, TX 75024 972-797-1200

MINOR PATIENT REGISTRATION UPDATE

PATIENT NAME ____________________ Male ___ Female ___
DATE of BIRTH ____________________ SS# ____________________
STREET ____________________ CITY ____________ STATE ________ ZIP ____________
HOME PHONE ____________________ ADDITIONAL PHONE ____________________
PEDIATRICIAN/PHYSICIAN ____________________ REFERRING PHYSICIAN ____________________
PHONE ____________________ PHONE ____________________

Parents/Legal Guardians

PLEASE COMPLETE FOR *BOTH* PARENTS

☐ MARRIED ☐ SEPARATED ☐ DIVORCED

PARENT'S NAME ____________________
SS # ____________ DOB ____________
ADDRESS ____________________
____
HOME PHONE ____________________
EMPLOYER ____________________
WORK PHONE ____________________
CELL PHONE ____________________
E-Mail Address ____________________

PARENT'S NAME ____________________
SS#: ____________ DOB ____________
ADDRESS ____________________
____
HOME PHONE ____________________
EMPLOYER ____________________
WORK PHONE ____________________
CELL PHONE ____________________
E-Mail Address ____________________

Insurance Information

Copy of card(s) will be taken

PRIMARY INSURANCE

Insurance Name: ____________________
Policy Number: ____________________
Group Number: ____________________
Subscriber Name: ____________________
Subscriber DOB: ____________________
Subscriber SS#: ____________________
Relationship to Patient: ____________________

SECONDARY INSURANCE

Insurance Name: ____________________
Policy Number: ____________________
Group Number: ____________________
Subscriber Name: ____________________
Subscriber DOB: ____________________
Subscriber SS#: ____________________
Relationship to Patient: ____________________

Insurance Authorization and Assignment

I hereby authorize my insurance carrier(s), including Medicare to issue payment directly to Pediatric Ophthalmology, P.A., for medical services rendered to myself and/or my dependent regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance.

I hereby authorize Pediatric Ophthalmology, P.A., to: (1) release any information to insurance carrier regarding my illness and treatment (2) to process claims generated in the course of examination, or treatment, and (3) to allow a photocopy of my signature to be used to process insurance claims.

____________________ ____________________
Signature Parent/Legal Guardian Date

Authorization

I hereby give my consent to the physicians and other clinical personnel of Pediatric Ophthalmology for the evaluation and treatment of my minor child on an ongoing basis.

I understand that I have the right to revoke this consent in writing, at any time, except when the physicians or other clinical personnel have already taken action on my consent.

I am responsible for co-payments, deductibles, and non-covered services at time of service.

____________________ ____________________
Signature Parent/Legal Guardian Date