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

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

ADULT PATIENT REGISTRATION UPDATE

Patient Name _____ Male ☐ Female ☐
Street _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Date of Birth _____ Social Security # _____
Referring Physician _____
First Name Last Name
Primary Physician _____
First Name Last Name
Employer _____
Address _____
Work Phone _____ Email _____
Emergency Contact _____ ***Phone*** _____

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 Patient/Legal Guardian Date

Authorization

I hereby give my consent to the physicians and other clinical personnel of Pediatric Ophthalmology for my evaluation and treatment 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 the time of service.

_____ _____
Patient/Legal Guardian Date