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
6130 W Parker Rd. #508 Plano, Tx 972-981-8430

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 _____	PARENT'S NAME _____
SS # _____ DOB _____	SS#: _____ DOB _____
ADDRESS _____	ADDRESS _____
_____	_____
HOME PHONE _____	HOME PHONE _____
EMPLOYER _____	EMPLOYER_____
WORK PHONE _____	WORK PHONE _____
CELL PHONE _____	CELL PHONE _____
E-Mail Address _____	E-Mail Address_____

Insurance Information

Copy of card(s) will be taken

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Insurance Name: _____	Insurance Name: _____
Policy Number: _____	Policy Number: _____
Group Number: _____	Group Number: _____
Subscriber Name: _____	**Subscriber Name: _____**
Subscriber DOB: _____	Subscriber DOB: _____
Subscriber SS#: _____	Subscriber SS#: _____
Relationship to Patient: _____	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