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

Dallas Office
7150 Greenville Ave., Suite 305
Dallas, TX 75231
214-369-6434

Grapevine Office
1631 Lancaster Dr., Suite 200
Grapevine, TX 76051
817-329-5433

Plano Office
6000 W. Spring Creek Pkwy., Suite 130
Plano, TX 75024
972-797-1200

MINOR PATIENT INFORMATION UPDATE

Patient Name_____ Date of Birth____/____/_____ Male_____ Female _____
Street _____ City_____ State_____ Zip_____
Primary Phone_____ □ Home □ Cell 2nd Phone_____ □ Home □ Cell
Pediatric Physician _____ Phone _____
Referring Physician_____ Phone _____

Parents/Legal Guardians
PLEASE COMPLETE FOR ***BOTH*** PARENTS

□ Married □ Separated □ Divorced □ Other

Parents Name _____
DOB _____
Address _____
_____
Cell Phone_____
Employer_____
Work Phone_____
Home Phone _____
Email_____

Parents Name_____
DOB _____
Address _____
_____
Cell Phone _____
Employer _____
Work Phone _____
Home Phone _____
Email _____

Insurance Information

PRIMARY INSURANCE
Insurance Name: _____
Member ID:_____
Group Number: _____
Member Name: _____
Subscriber DOB:_____
Relationship to Patient:_____

SECONDARY INSURANCE
Insurance Name: _____
Member ID: _____
Group Number: _____
Member Name: _____
Subscriber DOB: _____
Relationship to Patient: _____

My preferred method of communication: □ Text □ Email □ Phone

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.

_____ _____
Signature Patient/Legal Guardian Date