Patient Registration

Patient's Name :________________________________ ☐ MALE ☐ FEMALE
DOB: ______________________ Social Security #: ______________________
Address:____
City/State/Zip:______________________ Phone #: ______________________

Parent / Guardian Information (if patient is a minor)

Mother's Name:______________________DOB:__________SS#:______________
Address: ____
City/State/Zip:______________________Phone #: ______________________
Place of Employment:______________________Phone #: ______________________
Email Address: ______________________
*Is it ok to call you at work? ☐ YES ☐ NO *Is it ok to email you appointment reminders, paperwork, etc? : ☐ YES ☐ NO

Father's Name:______________________DOB:__________SS#:______________
Address: ____
City/State/Zip:______________________Phone #: ______________________
Place of Employment:______________________Phone #: ______________________
Email Address: ______________________
*Is it ok to call you at work? ☐ YES ☐ NO *Is it ok to email you appointment reminders, paperwork, etc? : ☐ YES ☐ NO

Emergency Contact Information

Name:______________________ Phone #: ______________________
Address: ____
City/State/Zip:______________________ Relationship to Patient: ______________________

Insurance Information

Primary Insurance: ____
Name of Policy Holder:______________________ Relationship to Patient: ______________________
DOB Of Policy Holder:______________________ Policy Holder's SS #: ______________________
Policy #: ______________________Group #: ______________________
Place of Employment: ____

Secondary Insurance: ____
Name of Policy Holder:______________________ Relationship to Patient: ______________________
DOB Of Policy Holder:______________________ Policy Holder's SS #: ______________________
Policy #: ______________________Group #: ______________________
Place of Employment: ____

Please provide your insurance card to copy for our records. Insurance co-pay/deductible and referral (if applicable) are due at the time of service. By signing below, you agree to these terms and authorize Pediatric Ophthalmology & Strabismus Associates to bill your insurance.

______________________________ ______________________
Patient/Parent/Guardian Signature Date