Central Eye Care, P.C.

Pediatric Ophthalmology and Strabismus

Patient Information Form

Patient Name (Printed): _____ *Date:* _____

*Address:*_____ *City:* _____ *State:* _____ *Zip Code:* _____

Date of Birth: _____ *Age:* _____ *Gender:* _____ *Social Security #:* _____

Marital Status: S M W D *Emergency Contact*: _____ Emergency Contact Ph #: _____

Primary Phone Number: _____ *Secondary Phone:* _____

How did you hear about us? _____

*Primary Care Physician: Dr.*_____ *Referring Physician: Dr.* _____

Pharmacy Name and Location: _____

NAME OF PRIMARY MEDICAL INSURANCE: _____

Contract/ID #: _____ *Group Number:* _____

If Other Than Self:
Policy Holder's Name: _____ *Relationship:* _____
Date of Birth: _____ *Social Security #:* _____

NAME OF SECONDARY MEDICAL INSURANCE: _____

Contract/ID #: _____ *Group Number:* _____

If Other Than Self:
Policy Holder's Name: _____ *Relationship:* _____
Date of Birth: _____ *Social Security #:* _____

NAME OF OTHER <u>MEDICAL OR VISION</u> INSURANCE: _____

Contract/ID #: _____ *Group Number:* _____

If Other Than Self:
Policy Holder's Name: _____ *Relationship:* _____
Date of Birth: _____ *Social Security #:* _____

I authorize the release of any medical information necessary to process claims and authorize payment of benefits to Central Eye Care, P.C. I understand I am responsible for any unpaid balance remaining on my account after insurance payment or in the case of insurance rejection.

Patient/Parent/Guardian's Signature: _____ *Date:* _____