Pediatric
Ophthalmology
Consultants
3200 S.W. 60 Court, Ste 103
Miami, Florida 33155-4072

Patient Information

Today's Date:_____

Patient Name:_____
Last First Middle

Date of Birth:_____ Sex: ❒ Male ❒ Female
Month Day Year

Address_____

City_____ State_____ Zip Code_____

Home Phone_____ Mobile_____ Work_____

Race: ❒ African ❒ Caucasian ❒ Hispanic ❒ Other_____

Preferred Language: ❒ English ❒ Spanish ❒ Creole ❒ Other_____

Email:_____

Referring Physician_____ Phone#_____

Primary Care Physician/Pediatrician_____ Phone#_____

Pharmacy_____ Address#_____

Parent(s)/Legal Guardian Information

Who has legal custody of the patient:

❒ Parents ❒ Mother Only ❒ Father Only ❒ Foster Parent ❒ Grandparent ❒ HR ❒ Other_____

Mothers Name_____ D.O.B. _____ SS#_____

Address ❒ Check if same as above

_____ City_____ State_____ Zip Code_____

Home Phone_____ Mobile_____ Work_____

Employer_____ Employer Address_____

Fathers Name_____ D.O.B. _____ SS#_____

Address ❒ Check if same as above

_____ City_____ State_____ Zip Code_____

Home Phone_____ Mobile_____ Work_____

Employer_____ Employer Address_____

Emergency Contacts

1. Name_____ Relationship_____ Phone_____

2. Name_____ Relationship_____ Phone_____

Insurance Information

1. Insurance Company_____ Relationship to Patient_____

Policy Holder Name_____ D.O.B. _____ SS#_____

Policy#_____ Group #_____

Claims Address_____ City_____ State_____ Zip Code_____

2. Insurance Company_____ Relationship to Patient_____

Policy Holder Name_____ D.O.B. _____ SS#_____

Policy#_____ Group #_____

Claims Address_____ City_____ State_____ Zip Code_____

Payment is expected IN FULL at the time services are rendered by the patient or person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit, you will be responsible for any payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient or Parent/Guardian Signature_____

Patient Name_____ Date_____