Patient:

DOB:

Date:

The Children and Family Eye Doctors, a division of Proliance Surgeons

CHILD REGISTRATION FORM (17 years of age and younger)

Gender: ☐ male ☐ female ☐ other

Address apt # City State Zip

Father's / Partner Name

Mother's / Partner Name

( ) Father's / Partner cell phone

( ) Home phone

OK to leave message? Yes ☐ No ☐

( ) Mother's / Partner cell phone

_____/_____/_____ (required for insurance billing)
Father's / Partner birth date

_____/_____/_____ (required for insurance billing)
Mother's/ Partner birth date

Address (if different from patient)

Address (if different from patient)

E-mail

E-mail

Employer

Employer

For billing purpose: Does child live with: ☐ mother & father; ☐ mother; ☐ father; ☐ other _____

Medical Insurance (Must provide unless cash pay)

PRIMARY Insurance Company _____ Subscriber Name _____
(person who insurance is under)

Subscriber's birthdate _____/_____/_____ (required for insurance billing)

SECONDARY Insurance Company _____ Subscriber Name _____

Subscriber's birthdate _____/_____/_____ (required for insurance billing)

Vision Service Plan (VSP) Subscriber's date of birth _____/_____/_____ Subscriber's last 4 digits of ss#_____

Primary Care Doctor phone

Referring Doctor phone

Practice name

Practice name

Office visit claims are submitted to insurance companies based solely on the diagnosis and exam performed by the physician. We cannot change billing for the purpose of maximizing insurance payment and/or minimizing patient financial responsibility. I hereby authorize the release of any medical or other information necessary to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I understand that I am financially responsible for any non-covered charges incurred by a collection agency in collecting any unpaid balances. Should the account be referred for collections, the undersigned, or their agent, will be responsible for payment of collection fees, reasonable attorney fees and court costs. **There is a $25.00 fee for appointments not cancelled within 24 hours prior to the appointment.**

Acknowledgement of Notice of Privacy Practices - Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknolwedge that you have reviewed the Notice of Proliance surgeons, Inc., P.S.

Signature of responsible party date