

# Child Registration Form

## PATIENT INFORMATION:

|   |                                     |              |                     |                                 |               |         |
|---|-------------------------------------|--------------|---------------------|---------------------------------|---------------|---------|
| <b>Patient Name:</b>  | _____                               | _____        | _____               | _____                           | _____         |         |
|   | Last                                | First        | MI                  | M/F                             | Date of Birth |         |
|   | Street                              | Apt #        | City                | State                           | Zip           | Phone # |
| <b>Father's Name:</b>   | _____                               |              |                     | DOB (Required for ins. billing) | SS#           |         |
|   | Address (if different from patient) |              |                     |                                 |               |         |
|   | Home phone                          | Office Phone | Cell Phone          | Email Address                   |               |         |
| <b>Mother's Name:</b>   | _____                               |              |                     | DOB (Required for ins. billing) | SS#           |         |
|   | Address (if different from patient) |              |                     |                                 |               |         |
|   | Home phone                          | Office Phone | Cell Phone          | Email Address                   |               |         |
| Referring Doctor  | Phone #                             |              | Primary Care Doctor | Phone #                         |               |         |
| Other family members seen in this office  |                                     |              |                     |                                 |               |         |
| Any correspondence should be sent to: <input type="checkbox"/> Mother & Father <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other |                                     |              |                     |                                 |               |         |

## INSURANCE INFORMATION:

|                                |                   |                 |               |
|--------------------------------|-------------------|-----------------|---------------|
| <b>Primary Insurance Co:</b>   | _____             | _____           | _____         |
|                                | Insurance Co Name | Subscriber Name | Date of Birth |
|                                | Insurance Address | SS# or ID#      | Group #       |
| <b>Secondary Insurance Co:</b> | _____             | _____           | _____         |
|                                | Insurance Co Name | Subscriber Name | Date of Birth |
|                                | Insurance Address | SS# or ID#      | Group #       |

I hereby authorize Northwest Pediatric Eye Care to release any medical or other information necessary in order 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 and any charges incurred by a collection agency in collecting any unpaid balances. **There is a \$35.00 fee for appointment not cancelled within 24 hours prior to your scheduled appointment.**

**CO-PAYMENT IS DUE AT THE TIME OF SERVICE**

\_\_\_\_\_  
Signature of responsible party

\_\_\_\_\_  
Date