



**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 _____