Eyes4Kids

Patient Information

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

Today's Date:

Patient Name: Last First Middle

Date of Birth: Month Day Year Sex: ☐ Male ☐ Female

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