PEDIATRIC
REGISTRATION FORM

MICROSURGICAL EYE CONSULTANTS

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Pediatric Ophthalmologist

PATIENT NAME _____ BIRTHDATE___/___/_____ ☐ M ☐ F AGE_____

RACE _____ ETHNICITY _____ PRIMARY LANGUAGE _____

ADDRESS_____CITY _____ STATE_____ ZIP_____

HOME # ( )_____ CELL # ( ) _____ SS # ____- ____ - _____

MOTHER'S NAME _____ EMAIL _____

EMPLOYER ADDRESS _____ WORK # ( ) _____

ADDRESS (*if different from patient*)_____ CITY _____ STATE _____ ZIP _____

FATHER'S NAME _____ EMAIL _____

EMPLOYER ADDRESS _____ WORK # ( ) _____

ADDRESS (*if different from patient*)_____ CITY _____ STATE _____ ZIP _____

FAMILY STATUS: PARENT ARE: ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

PATIENT IS: ☐ LIVING WITH PARENT(S) ☐ LIVING WITH RELATIVE, FOSTER PARENTS OR GUARDIAN

PEDIATRICIAN _____ ADDRESS _____ PHONE # ( ) _____

REFERRED BY _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____ POLICY HOLDER'S NAME _____

POLICY HOLDER'S SS # _____ POLICY HOLDER'S D.O.B. _____

INSURANCE ADDRESS _____

POLICY # _____ GROUP # _____

COMPANY NAME _____ COMPANY ADDRESS _____

ASSIGNMENT OF BENEFITS

Assignment of Benefits to Physician: I hereby authorize assignment of payments directly to Microsurgical Eye Consultants for the surgical and/or medical benefits, if any, otherwise payable to me for the services described above. I understand that I am financially responsible for the charges not covered by this authorization or insurance. I hereby authorize Microsurgical Eye Consultants to release any information relative to medical care received by me.

SIGNED _____ DATE _____
(Insured or Authorized Person)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I understand I may obtain a copy of this practice's Notice of Privacy Practices, which provides me with a complete description of the uses and disclosures of certain health information. I understand that I am entitled to receive a copy of this document.
This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices upon request.

SIGNATURE _____ DATE _____
(Name of Patient or Guardian)