Eye Surgery Associates
Diplomates, American Board of Ophthalmology

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- 2300 N. Commerce Pkwy, Suite 307, Weston, FL 33326 Tel: (954) 217-3155

PATIENT REGISTRATION (PEDIATRIC) **DATE** _____

First Name:	Middle Initial:	Last Name:		Phone Numbers: Home:
Address:			Apt Number:	
City:		State:	Zip Code:	Social Security
Sex: Male ( ) Female ( )		Age:	DOB:	Race/ Ethnicity/Language: / /

PARENT/GUARDIAN INFORMATION

Mother: First: Last:	**Family Situation**: ( ) Patient lives with both parents ( ) Patient lives with relatives, guardians or adoptive parents Parents are: ( ) Married ( ) Separated ( ) Divorced
Address (if different from patient):	Email:
Mother: Home #: Cell#: Work #	Employer:
Father: First: Last:	Address (if different from patient):
Father: Home #: Cell#: Work #	Employer:
	Email:

Family Physician or Pediatrician: Name: Tel:	Other Doctor(s) who should receive a report (please give name, specialty, address and phone)	Who Referred you to us: ( ) Pediatrician ( ) Optometrist ( ) Other:

INSURANCE INFORMATION:

Primary Insurance Company Name:		Who is the policy holder: ( ) Child ( ) Father ( ) Mother Primary Subscriber Name: DOB: Social Security #:
Policy (ID)Number:	Group #:	
Secondary Insurance Company Name:		Who is the policy holder: ( ) Child ( ) Father ( ) Mother Primary Subscriber Name: DOB: Social Security #:
Policy (ID)Number:	Group #:	

Physician's Release and Assignment: I authorize the release of Medical and other information necessary to process and receive payment on health insurance claims. I also request payment of benefits be made to my Provider. A copy of this authorization may be used in lieu of the original.

Financial Agreement: I understand that I am financially responsible for any charges incurred for services provided. If I have health insurance coverage and my provider is in network, I understand that I'm financially responsible for all co-payments, deductibles, and co-insurance associated with covered services. If I have out of network benefits and my provider is out of network, I understand that I will be responsible for higher co-insurance, deductibles, and co-payments. If I choose to have non-covered services performed, I will be responsible for the full payment of those charges. Outstanding patient balances over 60 days will incur a charge at the highest rate allowed by law. If my account is sent to collections for lack of payment I agree to pay my provider's fees and expenses incurred in collecting any such amounts, including without limitation, attorneys fees and costs.

I hereby consent to receive marketing materials from Provider from time to time.

Patient's / Guardian Signature _____