CHILDREN'S EYE CARE, PA

PERSONAL PATIENT INFORMATION

DEMOGRAPHICS:

Patient's (legal): First Name: _____ Middle Initial: _____ Last Name: _____

Patient's Address: _____ City: _____

State: _____ Zip: _____ Home Phone: ( )_____

Sex: _____ Date Of Birth: _____ Age: _____ Parents of Child/Name of Spouse: _____

If patient is a child, Parents are: (please circle) Single Married Divorced Widowed
Child lives with: parents grandparents other: _____

Mom/Dad/Patient Work #: ( )_____ Mom/Dad/Patient Cell #: ( )_____
(please circle one) (please circle one)
E-MAIL ADDRESS: _____ May we use to verify appointments? Yes__ No_____

Emergency Contact (not living with you): _____ Phone #: ( )_____

Primary Care Physician: _____ Phone #: ( )_____

BILLING INFORMATION:

Guarantor (person financially responsible): _____ Home Phone: ( )_____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: ( )_____

Relationship to Patient: __Self __Spouse __Parent __Other

Primary Medical Ins._____Member Name_____ Member DOB_____

Secondary Medical Ins._____Member Name _____Member DOB _____

Vision Insurance _____Member Name_____ID#_____

MEDICAL HISTORY:

Reason for Visit: _____

Are you allergic to any medications? _____

Current Medications (including supplements): _____

LIFETIME CONSENT:

I authorize the payment of insurance benefits to David E. Braverman, M.D., and authorize the release of information for the purpose of claim payment.

We will bill your insurance company based on the information you have provided. You are responsible and will be billed for any remaining balance that is not paid by your insurance company. This can include, but is not limited to, any co-payments, deductibles, refractions, co-insurance or non-covered services.

Signature: _____ Date: _____
(If patient is a minor, a parent or legal guardian must sign)