Pediatric Ophthalmology Associates, PA

Pediatric Ophthalmology---Pediatric and Adult Strabismus

William O. Young, MD

PLEASE PRINT

PATIENT INFORMATION

Name _____ DOB ___/___/___ Home Phone (____)_____-_____
First MI Last MM DD YY

Address _____ City _____ State ____ Zip _____

Sex: Male Female Primary Physician_____

Are other family members patients in our office? **Yes No** If yes, list:_____

Emergency Contact Name/Number _____

Whom may we thank for referring you? _____

FAMILY INFORMATION

Parent/Guardian _____ Relationship to patient _____

Address (if different from patient) _____City _____ State/Zip _____

Home Phone_____ Work Phone _____ Cell Phone _____

PATIENT'S INSURANCE INFORMATION

Name of Policyholder_____Relationship to patient _____

Date of Birth ____/____/____ Social Security # _____-_____-_____ Cell Phone (____) _____-_____
MM DD YY

Name of Employer _____ Work Phone (____)_____-_____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ ID # _____ Group # _____

If you have additional insurance, please complete information on page 2

Financial Agreement/Authorization to Release Information:

I understand that I am financially responsible for the medical care of the patient named above. I agree to pay for services as they are provided, unless they are covered by my insurance plan. If for any reason there is a balance remaining on my account, I agree to pay promptly upon receipt of the monthly statement. If I have questions about my bill, I may call 271-2007 for clarification.

I authorize Pediatric Ophthalmology Associates, PA, to release to insurance companies all information necessary for payment of claims for the patient's care, and to release to and/or obtain from other health care providers medical records as needed for the patient's care.

Signature _____Date _____

Office Use Only----
Photo ID _____ Family Members _____ Staff Initials _____

PATIENT INFORMATION-PAGE 2

Secondary Insurance

Name of Policyholder _____Relationship to patient _____

Date of Birth _____/_____/_____ Social Security # _____-_____-_____ Cell Phone (____)_____-_____
MM DD YY
Name of Employer _____ _Work Phone (____)_____-_____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ ID # _____ Group # _____

Tertiary Insurance

Name of Policyholder_____Relationship to patient _____

Date of Birth ____/____/____ Social Security # _____-_____-_____ Cell Phone (____)_____-_____
MM DD YY
Name of Employer _____ Work Phone (____)_____-_____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ ID # _____ Group # _____