Pediatric Ophthalmology of Erie: Child's Registration

Please print

Patient's name: _____
First Middle Last Nickname

SS#: ____-____-_____ Age: _____ Birth Date: ____/____/____ Sex: M F

Race: _____ Primary Language Spoken: _____

Are you of Spanish/Hispanic Origin Yes ( ) No ( )

Child's Home Phone #: (_____) _____-_____

Address: _____ Apt. #_____

City: _____ State_____ Zip Code: _____

Primary Care Doctor: _____

Persons to Whom Medical Info may be given: _____

Email: _____

GUARANTOR INFORMATION: *Person(s) Responsible for Payment of Account*

Mother's/Guardian Name: _____SS#:____-____-_____

Birth Date: ____/____/____ Home/Cell Phone No: (____) _____-_____

Employed By: _____ Work Phone: (____) ____-_____

Address (if different than Child's): _____

Father's/Guardian Name: _____SS#:____-____-_____

Birth Date: ____/____/____ Home/Cell Phone No: (____) _____-_____

Employed By: _____ Work Phone: (____) ____-_____

Address (if different than Child's): _____

In case of Emergency:

Nearest Relative other than Parents: _____

Address: _____

Phone # ____-____-_____ Relationship: _____

INSURANCE INFORMATION

Primary Insurance Name: _____

Policy Holder: _____ Relationship to patient_____

ID #: _____ Group #: _____ DOB: ___/___/_____

Secondary Insurance Name: _____

Policy Holder: _____ Relationship to patient_____

ID #: _____ Group #: _____ DOB: ___/___/_____

OFFICE POLICIES

No Show Policy

In order for Pediatric Ophthalmology of Erie, Inc. to provide the best care to our patients, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. Our office policy states that **after 3 missed appointments** per family you will be asked to find another eye care provider. *(Missed appointments are defined as ANY appointment in which at least 24 hours notice of cancellation was not given.)*

Signed by Parent/Guarantor: X_____

ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of Pediatric Ophthalmology of Erie, Inc. for the surgical and/or medical benefits, if any, and otherwise payable to me under the terms of my insurance. A copy of this authorization may be used in place of the original. This information is accurate and true to the best of my knowledge. I understand that I am responsible to pay for services rendered whether or not payable by said insurance. In the event payment is not made and the account is referred to a collection agency or attorney, I will pay the costs of collection including attorney's fees and costs incurred.

Signed by Parent/Guarantor: X_____

REFRACTION PAYMENT POLICY: *This policy **does not** apply to Medicaid patients*

Refraction is the process of determining the best possible visual acuity and function of your eye as well as the need for corrective lenses (spectacles or contacts). Congress has determined that the refraction is not a covered service by Medicare; most medical insurance plans follow Medicare guidelines, as well. Our fee for refraction is $35 and will be collected at the time of service in addition to any co-pays or deductibles your insurance plan may require. Should your plan pay us for the refraction, we will reimburse you accordingly.

DILATING EYE DROPS CONSENT

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the eye doctor to get a better view of the inside of your eye. Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your eye doctor to predict how much your/your child's vision will be affected. Because driving, for our adult patients, may be difficult immediately after an examination it is best if you make arrangements not to drive yourself.
I hereby authorize the physician and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

Patient's name: _____ Date: ___/___/_____

Patient's Signature: _____
(or person authorized to sign for patient)