Metropolitan Pediatric Ophthalmology

PATIENT REGISTRATION

NAME (LAST, FIRST INIT.)	HOME PHONE NO.	DATE OF BIRTH	AGE	SEX (M/F)

ADDRESS	CITY	STATE	ZIP CODE

SOCIAL SECURITY NO.	PRIMARY CARE PHYSICIAN/MEDICAL GROUP	ADDRESS

OCCUPATION	EMPLOYER	WORK PHONE	MARITAL STATUS S / M / D / W

NAME OF FRIEND OR RELATIVE (NOT AT SAME RESIDENCE)	PHONE

PRIMARY INS. INFO. PLEASE PROVIDE COPY....	INSURED'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

INSURANCE CO. NAME & ADDRESS

SUBSCRIBER NO.	GROUP NO.	EFFECTIVE DATE	CO-PAYMENT AMOUNT
			$

INSURED'S EMPLOYER AND OCCUPATION	WORK PHONE

SECONDARY INS. INFO. PLEASE PROVIDE COPY....	INSURED'S NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT

INSURANCE CO. NAME & ADDRESS

SUBSCRIBER NO.	GROUP NO.	EFFECTIVE DATE	CO-PAYMENT AMOUNT
			$

INSURED'S EMPLOYER AND OCCUPATION	WORK PHONE

OTHER FAMILY MEMBERS WHO HAVE BEEN SEEN IN THIS OFFICE ____________________

NAME OF SPOUSE (HUSBAND or WIFE) ____________________

OCCUPATION __________ EMPLOYER __________ WORK PHONE __________

IF PATIENT IS A MINOR OR STUDENT:

GIVE MOTHER'S NAME ____________________ HOME PHONE __________

HOME ADDRESS ____________________

OCCUPATION __________ EMPLOYER __________ WORK PHONE __________

GIVE FATHER'S NAME ____________________ HOME PHONE __________

HOME ADDRESS ____________________

OCCUPATION __________ EMPLOYER __________ WORK PHONE __________

PLEASE NOTE: If there is any question regarding the bill, the person who is registering today will be responsible for payment. If patient is a minor, the person registering for the patient will be responsible.

RELEASE STATEMENT:

1. I authorize METROPOLITAN PEDIATRIC OPHTHALMOLOGY, and his staff to perform diagnostic tests and provide treatment necessary for medical evaluation and health care for above mentioned patient.

2. I accept responsibility for all charges incurred in the medical evaluation and health care of the above-named patient.

3. I understand that ongoing primary medical care is the responsibility of the referring physician or another physician of my choice; it is not the responsibility of METROPOLITAN PEDIATRIC OPHTHALMOLOGY.
4. I hereby give permission to METROPOLITAN PEDIATRIC OPHTHALMOLOGY to provide relevant medical information about the above-named patient to

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(name and address of referring physician, clinic or hospital)

Signed ____________________ **Date** __________

____________________ **(relationship to patient)**