EYE PHYSICIANS OF CENTRAL FLORIDA

ACCOUNT NO# _____ **a Division of Florida Pediatric Associates, LLC**

PATIENT INFORMATION

Patient Name: _____ DOB: _____ SS#: _____ Sex: Male __ Female__

Address: _____ City:_____ State: _____ Zip: _____ Phone#:_____

Race: □African American □Asian □Caucasian □Chinese □Filipino □Hispanic □Japanese □Native American □Native Hawaiian □Pacific Islander □Other _____

Referring Physician: _____ Phone #: _____
Primary Care Physician: _____ Phone #:_____ _____
Pharmacy: _____ Pharmacy Phone # : _____

Email: _____

PARENT(S) / LEGAL GUARDIAN INFORMATION

Who has Legal Custody of the Patient: ( ) Parents ( ) Mother Only ( ) Father Only ( ) Foster Parent ( ) Grandparent ( ) HRS/Other

***** IF NOT BIOLOGICAL / NATURAL PARENTS, COURT DOCUMENTS MUST BE PRESENT AT TIME OF VISIT*****

Mother's Name: _____ DOB: _____ SS#: _____
Address: □ Check here if same as above
_____ City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Work #: _____
Employer _____ Employer Address _____

Father's Name: _____ DOB: _____ SS#: _____
Address: □Check here if same as above
_____ City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Work #: _____
Employer _____ Employer Address _____

EMERGENCY CONTACTS

1.Name: _____Relationship: _____ Phone: _____
2.Name: _____Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary #1 Insurance Carrier: _____ Relationship to Patient_____
Policy # _____ Group #_____
Policyholder's Name: _____ DOB_____ SS#_____ _____
Claims Address _____ City _____ State _____ Zip _____
Eligibility Phone _____ Co-Payment $_____ Deductible $_____

Secondary #2 Insurance Carrier: _____ Relationship to Patient_____
Policy # _____ Group #_____
Policyholder's Name: _____ DOB_____ SS # _____
Claims Address _____ City _____ State _____ Zip _____
Eligibility Phone _____ Co-Payment $_____ Deductible $_____

Payment is expected IN FULL at the time services are rendered by the patient or person accompanying the child for treatment. If our office is a participating provider with your insurance carrier, all non-covered services, co-pays, and or deductibles will be collected at the time of each visit. Arrangements for anything other than full payment at the time of service must be made prior to your appointment. It is the responsibility of the guarantor to understand and accept the guidelines set up within the individual's insurance plan. If you are unable to provide us with complete insurance information at the time of your visit, you will be responsible for payment of services IN FULL. I understand that I am financially responsible for any balance not covered by my insurance carrier.

I have read and understand the office policy for payment and agree to the terms as stated.

Patient or Parent/Guardian Signature _____ Date _____

Print Name: _____