ACCOUNT NO# ______________________

EYE PHYSICIANS OF CENTRAL FLORIDA

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: ____