Family Eye Care Registration and Consent Form

REGISTRATION INFORMATION

Date:_____

PATIENT INFORMATION (MUST BE UPDATED ANNUALLY OR WHEN CHANGES OCCUR)				
				MEDICAID #/ SSN
1	M / F			
2	M / F			
3	M/F			
4	M/F			
5	M/F			

PATIENTS HOME ADDRESS

Street Address	City	State	Zip	County	Country

INFORMATION (include description ex. home, cell]

Phone #:	Phone #:
Phone #:	Phone#:

PRIMARY GUARANTOUR- **Relationship** ☐ **Mother** ☐ **Father** ☐ SOCIAL SECURITY NUMBER

Name: Last	First	.MI.	
Street Address	City	Stat e	Zip
			EMAIL

PARENT OR GURADIAN - **Relationship** ☐ **Mother** ☐ **Father** ☐ **OTHER**

Name: Last	First	M.I.	y Number
Street Address	City	State	Zip
			EM AIL

PRIMARY CONTACT INFORMATION

Name	Relationship	Telephone #

PRIVATE/PRIMARV INSURANCE INFORMATION -

Insurance Company Name	Policy#	Group #	Eff. Date

Insurance Street Address	City	State	Zip	Country

Name of Policy Holder	Policy Holder's DOB	SSN#	Relationship to Child

Insurance Company Name	Policy #	Group#	Eff. Date

Insurance Street Address	City	State	Zip	Country

Name of Policy Holder	Policy Holder's DOB	SSN#	Relationship to Child

***** PLEASE ASK FOR ADDITIONAL FORM IF YOU NEED MORE ROOM.**

We must have a copy of ALL active insurance coverage and the card to file the insurance for you. Insurance cards must be brought in at every visit so that we can verify active coverage. If we do not have your insurance card you could be seen as a cash payment.

CONSENT FOR TREATMENT AUTHORIZATION/ ASSIGNMENT/ RESPONSIBILITY STATEMENT

I consent to have Family Eye care on duty and their assistants and consultants treat me (or my minor child in the facility. I consent to having (1) physical examination, (2) diagnostic procedures, (3) surgical and medical treatment, 4) local anesthesia given if necessary and (5) the prescription of medication.

I understand that I am financially responsible for all charges for services rendered to my minor child, including the remaining balance after payment of possible insurance benefits are paid.

I authorize payment of medical benefits for myself or my minor child directly to Family Eye Care I authorize the release of any medical information necessary to process this claim.

I have read this form or have had it read to me. I agree and understand what it says . I further acknowledge to have been shown the Notice of Privacy Policy. I have read and understood it. I have had all my questions answered on it. I hereby agree to the contents of the Notice of Private Policy shown to me.

(X _____

Date: _____

CONSENT FOR TREATMENT OF MINOR CHILD IN ABSENCE OF PARENT OR GUARDIAN

In this policy of Family Eye Care that either the parents, grandparents, or the guardian to bring the patient to see the doctor. In case of an emergency and the responsible party cannot be there, the following people can bring the patient to the doctor.

Please inform them that they may have to present proper ID.

Please list anyone other than the parents or legal guardians listed above that has permission to access your child's medical records, Obtain results for lab tests, or bring your child to Family Eye Care without your presence, and making medical decisions for his Or her treatment:

Name:	RELATIONSHIP	PHONE:
PREVIOUS PHYSICIAN'S NAME(S)		PHONE: