Adult Registration Form

PATIENT INFORMATION:

Patient Name: _____

Last | First | MI | M/F | Date of Birth

Street | Apt # | City | State | Zip | SS#

Home phone | Office Phone | Cell Phone | Email Address

Spouse's Name: _____

DOB (Required for ins. billing) | SS#

Office Phone | Cell Phone | Email Address

Referring Doctor | Phone # | Primary Care Doctor | Phone #

Other family members seen in this office

INSURANCE INFORMATION:

Primary Insurance Co: _____

Insurance Co Name | Subscriber Name | Date of Birth

Insurance Address | SS# or ID# | Group #

Secondary Insurance Co: _____

Insurance Co Name | Subscriber Name | Date of Birth

Insurance Address | SS# or ID# | Group #

I hereby authorize Northwest Pediatric Eye Care to release any medical or other information necessary in order to process insurance claims billed on my behalf. I also authorize payment directly to the doctor for any benefits available under my insurance plan. I understand that I am financially responsible for any non-covered charges and any charges incurred by a collection agency in collecting any unpaid balances. **There is a $35.00 fee for appointment not cancelled within 24 hours prior to your scheduled appointment.**

CO-PAYMENT IS DUE AT THE TIME OF SERVICE

Signature of responsible party | Date