EXCELLENCE IN EYE CARE SINCE 1977

DONALDSON EYE CARE

MEDICAL AND SURGICAL OPHTHALMOLOGY

DEPENDENT PATIENT INFORMATION

PERSONAL INFORMATION

Date _____ Thank you for answering each question

Name of Patient _____ **SOCIAL SECURITY #** _____

Mailing Address _____ City _____ State____ Zip _____

Physical Address (if different) _____ City _____ State____ Zip _____

Home Phone # _____ Cell Phone # _____

Responsible Party's E-mail _____

Male___ Female___ Marital Status _____ Age _____ Date of Birth _____

Primary language spoken _____ Race _____

Name of **Father** _____ Phone # _____ Cell Phone # _____

Father's date of birth _____ Social Security # _____

Father currently working? Full-Time ◉ Part-Time ○ Not Working ○ Retired ○ Disabled ○

Father's Employer _____ Phone Number _____

Occupation _____ Employer's Address _____

Does Dependent have insurance coverage through **Father's** work? Yes ○ No ○

Name of **Mother** _____ Phone # _____ Cell Phone # _____

Mother's date of birth _____ Social Security # _____

Mother currently working? Full-Time ○ Part-Time ○ Not Working ○ Retired ○ Disabled ○

Mother's Employer _____ Phone Number _____

Occupation _____ Employer's Address _____

Does Dependent have insurance coverage through **Mother's** work? Yes ○ No ○

Is this treatment for a work related illness or injury? Yes ○ No ○ If Yes, provide Worker's Comp Information: _____

Is this service to treat an illness or injury resulting from an automobile accident? Yes ○ No ○

If Yes, provide name, address and policy number of the automobile or non-automobile liability or no fault insurer:

_____

Emergency Contact (other than Parents): _____ Phone # _____ Relationship? _____

If you are a new patient, how did you find out about us? _____

Primary Care Doctor _____

RESPONSIBLE PARTY FOR MINOR OR DEPENDENT: _____

I hereby authorize payment of my medical and surgical insurance benefits to the above providers, as applicable. I understand I am financially responsible for any charge whether or not paid by said insurance. If co-payments and/or deductibles are designated by my insurance company or health plan, I agree to pay them to the above providers, as applicable. I authorize any holder of medical or other information about me to release any information required to process any and all claims for reimbursement on my behalf, or to treat my condition.

Copayments are due at the time of service. Most insurances require copays to be paid at the time of the visit. There may be a $25 patient charge for a second missed appointment without 24 hour notice.

After 90 days in patient responsibility without payment in full or payment arrangements, patient accounts will be sent to an outside collection agency. There may be an additional charge of $25.00 to any account sent to an outside collection agency.

Signature of Parent or Responsible Party _____

Print Name _____ **Address** _____