Patient Information Form – Child

Please print and complete form in its entirety Account # _____

Patient's legal name _____ Date _____
First Middle Last

Prefers to be addressed by _____ Birth date _____/_____/_____ Age _____

Sex: □ M □ F Patient social security # _____/_____/_____ Phone (_____) _____

Guardian's cell# (_____) _____ Guardian's email address _____

Preferred method of contact (circle): Cell / Email / Home phone Ethnicity _____ Race _____

Address _____
Include apartment# or box # City MO Zip code

Marital status of parents: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Child resides with _____

Father's name _____ DOB ____/____/___ Phone (_____) _____

Father's employer _____ Phone (_____) _____

Mother's name _____ DOB ____/____/____ Phone (_____) _____

Mother's employer _____ Phone (_____) _____

Nearest relative _____ Phone (_____) _____
Not living at same address as patient

Address _____
Include apartment# or box # City MO Zip code

Responsible party information

Responsible party _____ Relationship to patient _____

Responsible party's employer _____ Phone (_____) _____

Insurance information – please complete this section on the PATIENT

Medicaid # _____
State _____

Primary insurance information

Insurance carrier name _____ ID# _____ Group# _____

Subscriber's name _____ Subscriber's DOB _____/_____/_____

Subscriber's Social Security # _____-_____-_____

Secondary insurance information

Insurance carrier name _____ ID# _____ Group # _____

Subscriber's name _____ Subscriber's DOB _____/_____/_____

Subscriber's Social Security # _____-_____-_____

PLEASE COMPLETE ON REVERSE SIDE OF FORM

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and other pay a percentage of the charge. It is the responsibility of the patient and/or responsible party to pay any deductible amount, co-insurance, or any other balance not paid for by the insurance carrier. It is also the responsibility of the patient to confirm that the provider they are seeing is a contracted provider with the patient's insurance prior to being seen by this provider. I understand I will be responsible for payment in full for services rendered if I do not furnish the required referral forms.

ALL CO-PAYMENTS, CO-INSURANCE, and NON-COVERED FEES ARE DUE THE DATE SERVICES ARE RENDERED. In the event this account is assigned to a collection agency, **the patient and/or responsible party will incur all costs of collection and attorney fees in ADDITION TO THE ORIGINAL BALANCE.**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance, and other health plans to:

OZARK RETINA & MACULA
1230 E Kingsley, Suite A
Springfield, MO 65804

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges, paid or unpaid by the above said insurance. I hereby authorize Ozark Retina & Macula to release all information necessary to secure payment for services rendered.

Signed _____ □ PATIENT □ GUARDIAN □ OTHER _____

Printed Name _____ Date _____

PLEASE PROVIDE A COPY OF THE COURT ORDER SHOWING YOU AS THE GUARDIAN FOR OUR RECORDS.