The Pediatric Eye Care Center

5220 Flanders Dr.
Baton Rouge, La. 70808
Telephone #225-766-3437 Fax #225-766-3443

Acct# (for office use only)_____

Date: ___/___/___

PATIENT INFORMATION (please print)
Name: First_____MI_____Last_____

Date of Birth___/___/___ Age ____ Sex____ Single (__) Married (__) Other (__) SS#_____

Address_____City, State, Zip_____

Home Phone ( )_____ Work Phone( )_____

Cell Phone ( )_____ Patient's Employer_____

Spouse's Name _____ Spouse's SS#_____

Date of Birth ___/____/____ Work Phone ( )_____ Employer_____

EMAIL ADDRESS (To be notified by email for appointment reminders and/or specials from Children's Eyewear)

_____

INSURANCE INFORMATION (please present cards at each visit)

Primary Insurance Co. _____**Secondary** Insurance Co._____

Name of Insured _____ Name of Insured _____

Insured's ID#_____ Insured's ID#_____

Group #_____ Group #_____

Relationship to Patient _____ Relationship to Patient_____

IF PATIENT IS A MINOR:
Father's Name _____ Date of Birth ___/___/___

SS #_____

Address (if different from above)_____City, State, Zip_____

Home Phone (if different from above) ( )_____ Work Phone( )_____

Cell Phone ( )_____ Employer _____

Mother's Name _____ Date of Birth ___/____/____

SS #_____

Address (if different from above) _____ City, State, Zip _____

Home Phone (if different from above) ( )_____ Work Phone( )_____

Cell Phone ( )_____ Employer _____

ADDITIONAL INFORMATION NEEDED:

Other family members that are patients_____

Pharmacy of choice _____

In case of emergency, notify_____

Primary Care Physician _____

Referred by: Doctor _____ Friend ( ) Yellow pages ( ) Other ( )

MEDICAL RELEASE

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

SIGNATURE _____ DATE ____/____/_____

NOTICE OF NON-COVERED SERVICES

We will file claims with all plans with which we participate. However, certain procedures (including refraction) may not be covered by your insurance plan. If your service or procedure is not covered by your insurance plan, you will be responsible for payment in full at the conclusion of the visit. **PAYMENT FOR COPAYS, DEDUCTIBLES, AND NON-COVERED PROCEDURES IS EXPECTED AT THE TIME SERVICE IS RENDERED.**

Your signature at the bottom of this form signifies that you understand that the service needed may not be a covered benefit under your insurance plan and that you fully accept the fact that the charges incurred are out-of-pocket expenses and will not be reimbursed by your health care plan.

SIGNATURE _____ DATE ____/____/____

THERE WILL BE A CHARGE OF $25.00 FOR ALL NSF CHECKS. PAST DUE BALANCES AFTER 90 DAYS WILL BE CHARGED A $20.00 DELINQUENT CHARGE AND 1.5% MONTHLY INTEREST CHARGE ON THE UNPAID BALANCE.

NOTICE OF PRIVACY PRACTICES

I_____ have received the notice of Privacy Practices.

SIGNATURE: _____

DATE: _____