Southside Eye Care **CHILD INFORMATION**

Were you referred yes__ no__ **Referring Doctor** __________________ **General Physician** ____________________

Patient name______________________________(mdl)____(last)_____________________________________

SS#_____________________ Sex____Age____DOB____/____/____ Height_________Weight___________

Language______________Race___________Ethnicity__________________Address______________________

_________________________ZIP_________ **Name of Parent or legal guardian**__________________________

Parent Employer ___________________________________Employer address____________________________

Employer phone ___________________Home Phone ______________________Cell ______________________

Emergency Contact ______________________Relationship ____________________Phone ________________

INSURANCE INFORMATION ***Patients with no insurance must pay in full at the time of appointment. Co-pays or charges not covered by insurance are due at the time of visit. **We are UNABLE to bill your insurance without your insurance cards and identification**

Primary ins: ____I.D.#_______________________________________

Group #________________________Primary card holder _______________________DOB___/_____/_______

Relationship to patient___________________________

Secondary ins: ____I.D.#____

Group #________________________Primary card holder _______________________DOB___/_____/________

Relationship to patient___________________________

Tertiary ins: ____I.D.#____

Group #________________________Primary card holder _______________________DOB___/_____/________

Relationship to patient___________________________

INSURANCE FINANCIAL POLICY *Patients are responsible for any balance due if insurance does not pay for any reason* Patients are responsible for any pre-authorizations and/or referral forms required for payment *We will not become involved with any dispute you might have with your insurance company *Past due accounts may be subject to a 40% collection fee if referred to a collection agency.

I, the patient/guardian, have accurately and truthfully completed the above information and agree that all fees incurred are my responsibility regardless of insurance coverage. I certify that I have read and agree to the patient information and privacy policy of this office.

Parent/ Guardian signature ____Date _____________

E-mail____