Patient:

DOB:

Date:

CHILD REGISTRATION FORM (18 years of age and younger)

Gender: ☐ male ☐ female

Address apt # City State Zip

Father's / Partner Name Father's/Partner Social Security #

Mother's / Partner Name Mother's / Partner Social Security #

( ) Father's / Partner cell phone

( ) Home phone

( ) Mother's / Partner cell phone

OK to leave message? Yes ☐ No ☐

____/____/____ (required for insurance billing) Father's / Partner birth date

____/____/____ (required for insurance billing) Mother's/ Partner birth date

Address (if different from patient)

Address (if different from patient)

E-mail

E-mail

Employer

Employer

For billing purpose: Does child live with: __ mother & father; __ mother; __father; other _____

Medical Insurance

PRIMARY Insurance Company _____ Subscriber Name _____

Subscriber's birthdate ____/____/____ (required for insurance billing)

SECONDARY Insurance Company _____ Subscriber Name _____

Subscriber's birthdate ____/____/____ (required for insurance billing)

Vision Insurance

VSP ☐ YES ☐ NO Subscribers last 4 digits of ss# _____ Davis Vision ☐ Yes ☐ No ID _____

Primary Care Doctor phone

Referring Doctor phone

address

address

Office visit claims are submitted to insurance companies based soley on the diagnosis and exam performed by the physician. We cannot change billing for the purpose of maximizing insurance payment and/or minimizing patient financial responsibility. I hereby authorize the release of any medical or other information necessary 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 incurred by a collection agency in collecting any unpaid balances. Should the account be referred for collections, the undersigned, or their agent, will be responsible for payment of collection fees, reasonable attorney fees and court costs. **There is a $25.00 fee for appointments not cancelled within 24 hours prior to the appointment.**

Signature of responsible party date