CHILDREN'S EYE CENTER

Dave Lee, M.D.
Ellen R. Miller, M.D.
Dean Bancroft, O.D.

PATIENT INFORMATION AND AUTHORIZATION

TODAY'S DATE: _____

PATIENT'S LEGAL NAME: _____

OTHER PREVIOUS NAME(S): _____

SEX: ❑ M ❑ F DATE OF BIRTH: _____ AGE: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____

ADDRESS: _____

CITY: _____ STATE _____ ZIP: _____

MOTHER'S NAME: _____ DOB _____

WORK PHONE: (____) _____ HOME PHONE: (____) _____

CELL PHONE: (____) _____ EMAIL: _____

FATHER'S NAME: _____ DOB _____

WORK PHONE: (____) _____ HOME PHONE: (____) _____

CELL PHONE: (____) _____ EMAIL: _____

LEGAL GUARDIAN: (if different from above) _____

CHILD LIVING WITH: _____ PHONE: _____

FATHER SS # _____ MOTHER SS # _____

EMERGENCY CONTACT: _____ #_____

HOW DID YOU HEAR ABOUT US?

Referring Physician: _____ Phone: (____) _____

Referring Physician Address: _____ City: _____

Primary Care Physician: _____ Phone #: ( ) _____

NOTE! **IF YOUR INSURANCE REQUIRES A REFERRAL IT MUST BE OBTAINED BEFORE YOUR APPOINTMENT OR YOU WILL BE RESCHEDULED

COMPLETE IN FULL ENTIRE FORM!!

NOTE! FOR YOUR INSURANCE TO BE BILLED, THE FOLLOWING SECTION MUST BE FILLED OUT COMPLETELY AND A COPY OF YOUR INSURANCE CARD MUST BE MADE

MEDICAL INSURANCE: _____

POLICY #: _____ GROUP #: _____

NAME OF POLICY HOLDER: _____ SS #: _____

CIRCLE: DAD / MOM / SELF DOB: _____

ADDRESS OF POLICY HOLDER (If different than above): _____

CITY: _____ STATE: _____ ZIP: _____ PHONE # (____) _____

VISION INS: (CIRCLE) EYEMED / VSP / SPECTERA ID#: _____

SECONDARY INS: _____

POLICY #: _____ Group #: _____

Name of Policy Holder: _____ SS #: _____

CIRCLE: DAD / MOM / SELF DOB: _____

GIVE INSURANCE CARDS TO FRONT DESK

****PLEASE READ AND SIGN THE OTHER SIDE OF THIS FORM****

OUR OFFICE REQUIRES THIS FORM TO BE REDONE ON A YEARLY BASIS.

NOTE: COMPLETION OF ENTIRE FORM IS NEEDED, BEFORE YOUR CHART IS PUT UP TO BE SEEN.

OVER

CHILDREN'S EYE CENTER

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PAYMENT FOR SERVICES

PATIENT RESPONSIBILITY - You will be responsible for co-pays and any balances not covered or paid by insurance. Routine eye care is not covered by many insurances. Therefore, if there is not a medical diagnosis, we ask that you pay at the time of service. We will still bill your insurance for you and if they do pay, you will receive an immediate refund. If you do not have insurance, you are responsible for the full amount of the fees at the time of service. For your convenience, we do accept VISA, MASTERCARD, personal checks and cash.

The parent who brings the child to the office is ultimately responsible for payment of the fees regardless of who the insured party is. If a person other than a parent brings a child, they are responsible for payment of the fees at the time of service unless they have all of your insurance information including a copy of the insurance card that includes a billing address.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION - I authorize the release of any medical information acquired or required during the course of the examination and ongoing treatment by The Children's Eye Center. I understand that The Children's Eye Center will correspond with and may otherwise convey information regarding the patients' medical status to the referring physician, the primary care physician and insurance companies as requested.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS - I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance and other health plans to the Children's Eye Center. I also authorize the release of any medical and/or other information necessary to process the claim.

NOTICE OF IMPAIRED VISION - (For Adults) I understand that the examination I receive may impair my vision and/or operation of mechanical equipment. I also realize that I may be unable to react with normal speed and accuracy. I have been advised that a driver should accompany me. I will make arrangements for my own transportation.

OUR OFFICE POLICY REQUIRES THE FRONT OF THIS FORM MUST BE COMPLETED IN ITS ENTIRETY!

_____ (INITIAL) I have received the Children's Eye Center Notice of Privacy Practices and I have been provided the opportunity to review it.
Date _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE PRECEDING DOCUMENT AND THAT THE INFORMATION I HAVE PROVIDED IS CORRECT.

_____ _____
SIGNATURE **DATE**

(THIS FORM EXPIRES ONE YEAR FROM THIS DATE.)

8890 N. Union Blvd., #205
Colorado Springs, Colorado 80920
719/574-1654 Fax 719/574-5381