PATIENT # _____

Administrative Office:
124 Graham Park Dr, Suite 300
Cranberry Township, PA 16066-6133
(724) 772-3388
fax: (724) 772-7021

North Office:
124 Graham Park Dr, Suite 300
Cranberry Township, PA 16066-6133
(724) 772-3388
fax: (724) 772-7021

Pediatric Ophthalmology & Adult Strabismus

Pittsburgh, Pennsylvania

www.eyemdsforkids.com

East Office:
Old William penn Prof. Bldg
4750 Old William Penn Highway
Murrysville, PA 15668
(724) 772-3388
fax: (724) 772-7021

South Office:
Meadows Professional Center
1385 Washington Road (Rt 19)
Washington, PA 15301
(724) 772-3388
fax: (724) 772-7021

PATIENT INFORMATION GUIDE - Please complete and bring with you to your appointment. Please Print.

LAST NAME | FIRST NAME | MIDDLE INITIAL

STUDENT STATUS (CIRCLE ONE) Full Part None | MARITAL STATUS (CIRCLE ONE) M S W D | DATE OF BIRTH | AGE | GENDER | SOCIAL SECURITY NUMBER

STREET ADDRESS | CITY | STATE | ZIP CODE

PRIMARY PHONE# _____ | SECONDARY PHONE# _____ | EMAIL ADDRESS (to send appointment reminders)

PRIMARY CARE DR. (INDIVIDUAL Dr. Name NOT GROUP) | STREET ADDRESS | CITY/STATE/ZIP | OFFICE TELEPHONE

PARENT/ GUARDIAN/ SPOUSE oF PATIENT | ADDRESS (if not the same as patient's) | PHARMACY PHONE #

REFERRING DOCTOR | STREET ADDRESS | CITY/STATE/ZIP | PHONE #

HOSPITAL / URGENT CARE (CLOSEST TO YOUR HOME) | PHONE NUMBER

HOW DID YOU HEAR ABOUT OUR GROUP? PCP__ FRIEND __ MAGAZINE __ WORD OF MOUTH ___ OTHER____

RACE: CAUCASIAN____ AFRICAN AMERICAN _____ HISPANIC _____ ASIAN _____ OTHER _____

INSURANCE INFORMATION: In order to make processing your insurance faster and more efficient please sign where indicated. This will insure proper attention and care of your insurance needs.

PRIMARY INSURANCE COMPANY

NAME OF POLICY HOLDER | DOB

POLICY HOLDER'S EMPLOYER | TELEPHONE NUMBER

IDENTIFICATION NUMBER | GROUP NUMBER | DATE EFFECTIVE

SECONDARY INSURANCE COMPANY

NAME OF POLICY HOLDER | DOB | HOME PHONE NUMBER | HOME ADDRESS

IDENTIFICATION NUMBER | GROUP NUMBER | EFFECTIVE DATE

Pediatric Ophthalmology and Strabismus, Inc. and Pediatric Eyewear, Ltd. are in compliance with Health Insurance Portability and Accessibility Act of 1996 (HIPPA), designed to tell you how we may, under federal law, use or disclose your health information. I understand the risks associated with communication by email Precautions will be taken to preserve the confidentiality of emails between POS/PEL and patients. However, this cannot be guaranteed and sensitive material should be conveyed by more secured methods. **Please make sure we have your signature on the reverse side of this document. I have read and understand the information on both sides of this form.**

Signature _____ **Date** _____

****A copy of your signature is valid as an original.****

Pediatric Ophthalmology & Adult Strabismus

UPDATE	
Initials &	Date

You must provide us with your insurance card to copy. If you do not have your card with you, you will be classified as self-paying until you send us a copy of your insurance card.

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. Necessary forms will be completed to expedite insurance carrier payments after payment is received from the patient. Copayment is requested at the time of the visit.

THE PATIENT IS RESPONSIBLE FOR FEES, regardless of insurance coverage. It is customary to pay for services when rendered unless other arrangements have been made in advance.

AUTHORIZATION TO PAY BENEFITS TO THE PHYSICIAN: I hereby certify the above named services were rendered and direct payment may be made to the physician named hereon. I am financially responsible for charges not covered by my insurance.

RELEASE: I agree that recognizable photographs and/ or video documentation and description of me or my child(s) eye (s) may be published in medical journals or be presented to scientific medical groups and will not be altered.

DECLARATION: Our doctors and chief optician declare a financial interest in our eyewear shop - Pediatric Eyewear, Ltc.

"I request that payment of authorized Insurance benefits be made either to me or on my behalf of Pediatric Ophthalmology and Strabismus, Inc. for any services furnished to me by physician or supplier. I authorize any holder of medical information about me to release to the health Care Financing Administration and its agents any information needed to determine these benefits payable for related services."

CONSENT FOR TREATMENT IN THE ABSENCE OF PARENT/GUARDIAN

I hereby give permission and written consent to Pediatric Ophthalmology and Strabismus, Inc, its physicians and employees to render any and all medical treatment as deemed necessary. This permission applies to only the people who are listed below:

1. _____ 2. _____

PRIOR EXPRESS CONSENT: As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a pre-recorded message. By providing your cell number & home number you consent to receiving such calls at the number you provided. Opting in is not required for medical treament. Your information will not be disclosed or sold to any 3rd parties.

Parent/Legal Guardian Signature:_____**Date**_____

A COPY OF THIS SIGNATURE IS AS VALID AS AN ORIGINAL

*****A fee of $25.00 will be charged for missed appointments. *****

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