RETINA OF COASTAL CAROLINA

PATIENT REGISTRATION FORM FOR MINORS

INFORMATION OF MINOR

Last Name of Minor:	First Name:	Middle:
Permanent Address:		County:
City:	State:	Zip:
Home phone: **( )**	Alternate phone: **( )**	Date of Birth: / / Age
Sex**:** **( )**Male **( )**Female	Social Security Number:	
Pref Language:	Race (Circle One):	American Indian or Alaska Native/ Asian / African American / Native Hawaiian or Other Pacific Islander / White / Other
Hispanic or Latino: Yes / No		
Preferred method of contact (Circle One): Home Phone / Cell Phone / Mail (USPS) / Secure Email / Text (SMS) / Patient Portal / No Preference / No Reminders		

INFORMATION OF PARENT OR GUARDIAN

Relationship to Minor: _____Parent _____Guardian _____Other (Please Specify) _____

Last Name:	First Name:	Middle:
Mailing Address:		County:
Street Address:		
City:	State:	Zip:
Home phone: **( )**	Work phone: **( )**	Date of Birth: / / Age
Sex**:** **( )**Male **( )**Female	Social Security Number:	
Marital Status: **( )**Married **( )**Single **( )**Widowed **( )**Separated **( )**Divorced		
Occupation:	Employer:	
Address:		
Spouse's name:	Social Security #:	Date of Birth: / /

RESPONSIBLE PARTY (Parent, Guardian or Power or Attorney)

Name:	Relationship:	
Street Address:		
Mailing Address:		
City:	State:	Zip:
Home phone: **( )**	Work phone: **( )**	Date of Birth: / / Age
Sex**:** **( )**Male **( )**Female	Social Security Number:	

DOCTOR INFORMATION

Eye Doctor's Name:	City:	phone: **( )**
Pediatrician's Name:	City:	phone: **( )**
Pharmacy Name:	City:	phone: ( )

REFERRAL INFORMATION

Patient was referred by: **( )**Doctor _____ **( )**Friend/Patient **( )**Newspaper **( )**Radio **( )**Television **( )**Yellow pages **( )**Internet **( )**Other (specify):

Reason for being referred?

Today's Date: _____ Update: _____

RETINA OF COASTAL CAROLINA

INSURANCE INFORMATION

PRIMARY INSURANCE:	
ID NUMBER:	
POLICY HOLDER:	
Social Security #:	Date of Birth: / /

SECONDARY INSURANCE:	
ID NUMBER:	
POLICY HOLDER:	
Social Security #:	Date of Birth: / /

TERTIARY INSURANCE:	
ID NUMBER:	
POLICY HOLDER:	
Social Security #:	Date of Birth: / /

HOW WILL YOU PAY FOR ANY COPAYMENT, DEDUCTIBLE OR CO-INSURANCE?

( )CASH **( )**CHECK **( )**CREDIT CARD

ASSIGNMENT AND RELEASE

I give my permission for Retina of Coastal Carolina to; 1) release to the Social Security Administration or other insurance carriers, information concerning my insurance claim, 2) file my insurance claim with Medicare or an insurance company and assign the benefits paid to Retina of Coastal Carolina, 3) contact any medical professional whom my doctor deems necessary for the furtherance of my medical care, 4) to leave a message reminding me of a medical/surgical appointment on any answering machine at my telephone home number, and 5) to leave a message reminding me of a medical/surgical appointment with any person answering my telephone.

I understand that; 1) my consent is good for all services for the remainder of my life, and 2) I am responsible for any unpaid balance not paid by my insurance company.

I certify that the information I have given is correct and that I have complete authority to execute this document on behalf of myself or the patient.

( ) I do not wish to have messages about my medical/surgical appointments left on my answering machine or with anyone other than me.

SIGNATURE OF _____ DATE:_____

RESPONSIBLE PARTY: