

PLEASE PRINT CLEARLY

TODAY'S DATE: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ SEX: ( M F )

PATIENT'S NAME: \_\_\_\_\_ NICKNAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
Street City State Zip

HOME PHONE: ( ) ALTERNATE PHONE: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ WK #: \_\_\_\_\_ CELL #: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
(If Different From Above) Street City State Zip

MOTHER'S NAME: \_\_\_\_\_ WK #: \_\_\_\_\_ CELL#: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_  
(If Different From Above) Street City State Zip

EMERGENCY CONTACT: \_\_\_\_\_  
Name Phone Relation

INSURANCE INFORMATION

PRIMARY INSURANCE: \_\_\_\_\_ POLICY HOLDERS NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

SECONDARY INSURANCE: \_\_\_\_\_ POLICY HOLDERS NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

HOW DID YOU HEAR ABOUT LARSON EYE CENTER, Ltd.? Please check one of the following:

\_\_\_\_ DOCTOR (NAME: \_\_\_\_\_) \_\_\_\_\_ FAMILY  
\_\_\_\_ FRIEND \_\_\_\_\_ INSURANCE \_\_\_\_\_ WEBSITE \_\_\_\_\_ NEWSPAPER  
\_\_\_\_ OTHER (Please specify): \_\_\_\_\_

RELEASE OF INFORMATION-PAYMENT AUTHORIZATION

I request that payment of insurance benefits be made payable directly to Larson Eye Center, Ltd. for any services furnished to me by that provider. I authorize Larson Eye Center, Ltd. to release to my insurance carrier any information needed to determine those benefits or the benefits payable to the related services.

I understand that I am financially responsible for any charges not covered by insurance.

**If I default and do not pay, Larson Eye Center, Ltd. is entitled to the right of recovery of all collection expenses up to 33%, including all court costs and reasonable attorney's fees incurred for the purpose of securing payment.**

This authorization is in effect until I choose to revoke it.

\_\_\_\_\_  
Signature of Requesting Parent

\_\_\_\_\_  
Date