

CREATIVE OPTICAL, LLC
2012 MINOR REGISTRATION FORM
(PLEASE PRINT)

Today's Date:		Primary Care Physician:			
PATIENT INFORMATION					
Patient's Last Name:			First Name:		Middle:
Birth Date:	Age:	SSN:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Street Address:			City:	State:	Zip:
P.O. Box Address:				Home Ph: ()	
PARENT/LEGAL GUARDIAN INFORMATION					
Parent/Legal Guardian Last Name:			First Name:		Middle:
Birth Date:	Age:	SSN:		Home Ph: ()	
Street Address:			City:	State:	Zip:
P.O. Box Address:			E-Mail:	Cell Ph: ()	
Occupation:	Employer:			Work Ph: ()	
Parent/Legal Guardian Last Name:			First Name:		Middle:
Birth Date:	Age:	SSN:		Home Ph: ()	
Street Address:			City:	State:	Zip:
P.O. Box Address:			E-Mail:	Cell Ph: ()	
Occupation:	Employer:			Work Ph: ()	
MEDICAL INSURANCE INFORMATION					
Is this patient covered by medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				Insurance:	
Policy Number:			Group Number:	Co-pay: \$	
Subscriber's Name:	Subscriber's SSN:	Birth Date:	Patient relationship to subscriber: <input type="checkbox"/> Dependant <input type="checkbox"/> Other		
Please indicate other medical insurance (list on back if needed).				Insurance:	
Policy Number:			Group Number:	Co-pay: \$	
Subscriber's Name:	Subscriber's SSN:	Birth Date:	Patient relationship to subscriber: <input type="checkbox"/> Dependant <input type="checkbox"/> Other		
VISION INSURANCE INFORMATION					
Is this Patient covered by vision insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No				Insurance:	
Policy Number:			Group Number:	Co-pay: \$	
Subscriber's Name:	Subscriber's SSN:	Birth Date:	Patient relationship to subscriber: <input type="checkbox"/> Dependant <input type="checkbox"/> Other		
IN CASE OF EMERGENCY					
Name of local friend or relative: (not living at same address)		Relationship to Patient:	Home Ph: ()	Work Ph: ()	
Referred to clinic by (Please check one box): <input type="checkbox"/> Doctor <input type="checkbox"/> Family <input type="checkbox"/> Friend <input type="checkbox"/> Yellow pages <input type="checkbox"/> Other					
Other family members seen here:					
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Jefferson Eye Surgeons or insurance company to release any information required to process my claims.					
_____ Parent / Legal Guardian signature				_____ Date	

CREATIVE OPTICAL, LLC
2012 MINOR REGISTRATION FORM
(PLEASE PRINT)