

Administrative 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

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

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 # _____

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	MARRITAL 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 POSPEL 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 _____ **A copy of your signature is valid as an original.** Date _____





Pediatric Ophthalmology

& Adult Strabismus

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 treatment. 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

UPDATE	
Initials	Date

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