WATERTOWN EYE CENTER / CENTER FOR SIGHT

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: ☐ M ☐ 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? ☐ Yes ☐ No			Insurance:		
Policy Number:			Group Number:	Co-pay: $	
Subscriber's Name:	Subscriber's SSN:	Birth Date:	Patient relationship to subscriber: ☐ Dependant ☐ 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: ☐ Dependant ☐ Other		
VISION INSURANCE INFORMATION					
Is this Patient covered by vision insurance? ☐ Yes ☐ No			Insurance:		
Policy Number:			Group Number:	Co-pay: $	
Subscriber's Name:	Subscriber's SSN:	Birth Date:	Patient relationship to subscriber: ☐ Dependant ☐ 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): ☐ Doctor ☐ Family ☐ Friend ☐ Yellow pages ☐ 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 Watertown Eye Center / Center For Sight or insurance company to release any information required to process my claims.

_____ _____

Parent / Legal Guardian signature *Date*

Revised 3/25/14