Associated Ophthalmologists

Dr. David Morimoto   Dr. Aras Zlioba

219 N. Hammes Ave.

Joliet, Illinois 60435

MINOR REGISTRATION FORM

Patient Last Name: ___________________ **First Name:** _____________________________ **Sex: Male. Female**

Date of Birth _____________________ **SS#** ___________________________ **Phone:** _____________________

Address: ____

City ______________________________ **State:** ______________________ **Zip** _________________

Pediatrician/Primary Physician: __________________________ **Referring Physician:** ______________________________

Parent Information:

Mother's Name ___________________________ **DOB:**_________________ **SS#** __________________________________

Home # _________________________ **Work #** _______________________ **Call #** _________________________________

Employer Name: _________________________________ **Address:** ____

City: ____________________________ **State:** _______________________ **Zip:** ________________

Father's Name: ___________________________ **DOB:**_________________ **SS#** __________________________________

Home # _________________________ **Work #** _______________________ **Call #** _________________________________

Employer Name: _________________________________ **Address:** ____

City: ____________________________ **State:** _______________________ **Zip:** ________________

Legal Guardian ____

Parent bringing child in for the appointment will be responsible for charges

Insurance Information

Primary Insurance: ____________________________________ **ID #** _____________________________ **Group#** ___________

Insured Last Name: ____________________ **First Name:** ____________________ **DOB:** _______________

SS# _____________________ **Relationship to the patient** _______________________________________

Secondary Insurance: ______________________ **ID #** _____________________________ **Group#** ___________

SS# _____________________ **Relationship to the patient** _______________________________________

I hereby authorize and direct my insurance benefits to be paid directly to Associated Ophthalmologists. I also authorize release of information regarding medical records. As the Parent/Guardian of the above patient. I consent to treatment of the said patient. I understand I am financially responsible for any fees incurred, including fees for medical services not covered by my insurance. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered and valid as the original.

Signed ___________________________________ **Date:** ___________________________

Relationship to Patient: ____