WELCOME TO

SPRING HILL EYECARE PLLC

See What You've Been Missing!

1. ABOUT YOUR CHILD

Today's Date:_____/_____/_____

Child's Name:_____
LAST FIRST MI

Preferred Name:_____ ☐Boy ☐Girl

Birthdate:____/_____/_____ Age:_____SS#____-_____-_____

Child's Address:_____

City:_____State:_____Zip:_____

Child's Home Phone #: (_____)_____-_____

School:_____Grade:_____

Name of Primary Care Doctor:_____

Primary Care Doctor's Office:_____

2. CHILD'S FAMILY INFO

Mother's Name:_____

☐Home info is same as child's ☐Step-Mother ☐Guardian

Address:_____

City:_____State:_____Zip:_____

Home Phone #: (_____)_____-_____

Work Phone #: (_____)_____-_____ Ext:_____

Cell Phone #:(_____)_____-_____

E-mail Address:_____

Mother's SS#:_____-____-_____ Date of Birth:___/___/_____

Employer:_____How long?_____

Employer's Address:_____

City:_____State:_____Zip:_____

Father's Name:_____

☐Home info is same as child's ☐Step-Father ☐Guardian

Address:_____

City:_____State:_____Zip:_____

Home Phone #: (_____)_____-_____

Work Phone #: (_____)_____-_____ Ext:_____

Cell Phone #:(_____)_____-_____

E-mail Address:_____

Father's SS#:_____-____-_____ Date of Birth:___/____/_____

Employer:_____How long?_____

Employer's Address:_____

City:_____State:_____Zip:_____

NOTE: The parent/guardian/adult accompanying a minor child is responsible for full payment on the day services are provided if not covered by insurance.

3. VISION INSURANCE INFO

Primary *VISION* Insurance

Co. Name:_____

Insured's ID#/SS#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____Birthdate:____/_____/_____

Insured's Employer:_____

***Secondary VISION* Insurance**

Co. Name:_____

Insured's ID#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____Birthdate:____/_____/_____

Insured's Employer:_____

4. MEDICAL INSURANCE INFO

Primary *MEDICAL* Insurance

Co. Name:_____

Insured's ID#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____Birthdate:____/_____/_____

Insured's Employer:_____

***Secondary MEDICAL* Insurance**

Co. Name:_____

Insured's ID#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name:_____

Relation:_____Birthdate:____/_____/_____

Insured's Employer:_____

5. MARKETING INFO

How did you learn about Spring Hill Eyecare, PLLC/Whom may we thank for referring you? (Please check all that apply)

☐ Friend/Family Member(name/relation):_____ ☐ Phone Book(which book?):_____

☐ Another Doctor(name):_____ ☐ Newspaper(which paper):_____

☐ Internet search(which search engine)_____ ☐ Drive-by/Sign

☐ Insurance directory/website:_____ ☐ Other:_____

6. CONSENT

By signing this form, I consent to treatment on behalf of the Minor for which this information pertains. I give permission for the doctor(s) to examine, diagnose and initiate treatment as deemed appropriate. I further attest, that I am the Parent or Legal Guardian of the Minor and have the authority to authorize care and treatment. ☐Consent via written note ☐Consent via phone ☐Consent via fax

Parent/Guardian Signature:_____Date:___/___/_____