

Children's Registration Form

Eastside Family Vision Care 12040 98th Ave. NE, Ste. 104 Kirkland, WA 98034 Ph 425.820.2143 Fax 425.820.2147
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Neena Gabrielle, O.D., FCOVD

Child's Name (Last, First) _____ Male Female

Child's Nickname _____ Birthday _____ Age _____

Address _____

School _____ Grade _____

Would you like us to send summaries of your child's evaluation to his/her school? Yes No

Mother's Name _____

Father's Name _____

Mother's Address _____

Father's Address _____

Mother's Employer _____

Father's Employer _____

Work Phone _____

Work Number _____

Does child live with: Mother & Father Mother Father Other _____

Other family members seen in our office: _____

Who referred you to our office today?

Name: _____ Physician OT PT SLP Teacher Friend/Family

Other: Insurance Web Search Advertisement (type) _____ Other _____

If you were referred by a medical provider, please provide the following information:

Name of Clinic _____

Specialty of Medical Provider _____

Would you like us to send summaries of your child's evaluations to his/her referring medical provider? Yes No

Primary Care Physician Information

Physician Name _____

Phone Number _____

Address _____

Would you like us to send summaries of your child's evaluations to his/her primary care physician? Yes No

Emergency Contact Information

Name: _____ Relationship _____ Phone # _____

I hereby give Eastside Family Vision Care permission for evaluation and treatment of my child. I hereby authorize the release of any medical or other information necessary to process insurance claims when needed. I also authorize payment directly to the doctor for any benefits available as a non-contract provider under my insurance plan. I understand that I am financially responsible for any non-covered charges and charges incurred by a collection agency in collecting any unpaid balances. I understand that Dr. Neena Gabrielle is a non-contract provider for all insurance plans and the amount due for the visit is my responsibility. In cases where EFVC can bill my insurance as a non-contract provider, I understand that I am responsible for the balance of the bill; otherwise I am responsible for all other fees at the time of service. I understand that it is my responsibility to keep track of amounts needed to reach my deductible (if applicable). I understand that it is my responsibility to obtain any referrals from my PCP as outlined by my insurance policy.

Signature of Responsible Party

Date

Staff Initials

Date