

# WELCOME TO

SPRING HILL



## 1. ABOUT YOUR CHILD

Today's Date: \_\_\_/\_\_\_/\_\_\_ File #: \_\_\_\_\_  
Child's Name: \_\_\_\_\_ MI  
LAST FIRST  
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: \_\_\_\_\_  
Primary Care Doctor's Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## 3. CHILD'S FAMILY INFO

### Who is accompanying the child today?

Mother  Father  Step-Mother  Step-Father  Guardian

Other → Relation: \_\_\_\_\_ → Full Name: \_\_\_\_\_

How many siblings? \_\_\_\_\_ Age(s): \_\_\_\_\_

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: \_\_\_/\_\_\_/\_\_\_

Mother's Driver's License: \_\_\_\_\_ State: \_\_\_\_\_

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: \_\_\_/\_\_\_/\_\_\_

Father's Driver's License: \_\_\_\_\_ State: \_\_\_\_\_

Employer: \_\_\_\_\_ How long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

## 2. INSURANCE INFO

### Primary Vision Insurance

Co. Name: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Insured's Employer: \_\_\_\_\_

Check if you have Secondary Vision Insurance

### Primary Medical Insurance

Co. Name: \_\_\_\_\_

Insured's ID#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_

Insured's Employer: \_\_\_\_\_

Check if you have Secondary Health Insurance

## 4. ACCOUNT INFO

**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. In divorce cases, the parent who brings the child in for services is the responsible party.

\_\_\_\_\_ = Initials of accompanying adult.

### Person ultimately responsible for account:

Mother  Father  Step-Mother  Step-Father  Guardian

See contact info in Section 3

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SS#: \_\_\_-\_\_\_-\_\_\_ Driver's License#: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

**Preferred payment method for any balance not covered by insurance company.:**  Cash  Check  Visa  Mastercard

Card # \_\_\_\_\_ Exp. \_\_\_/\_\_\_/\_\_\_

## 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 (name): \_\_\_\_\_  Phone Book (which book): \_\_\_\_\_

Family Member (name/relation) \_\_\_\_\_  Drive-by/Sign: \_\_\_\_\_

Internet search (which search engine) \_\_\_\_\_  Newspaper ad (which paper): \_\_\_\_\_

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: \_\_\_/\_\_\_/\_\_\_