CHILD REGISTRATION FORM

EYE CLINIC OF FAIRBANKS

WELCOME

We are pleased to welcome you to our practice.
Please take a few minutes to fill out this form as accurately as possible.
We will be happy to answer any questions you may have.

116 Minnie Street Fairbanks, Alaska 99701-3006 **(907) 458-7760**

Please print

PATIENT INFORMATION

Patient's Last Name	First Name	Middle Initial	Date of Birth	Sex	Social Security No. – –

Mailing Address	City	State	Zip Code

PARENT/GUARDIAN INFORMATION

CUSTODIAL RESPONSIBILITY

Name Mr. Ms. Mrs.	Relationship to Patient	Date of Birth	Sex	Social Security No. – –

Mailing Address	City	State	Zip Code

Alternate Address, if any	Email Address:

Home Phone	Work Phone/Ext.	Cell Phone	Pager	Your Pharmacy Name	Phone Number

Best time and place to reach you	Employer (If self, name of business)	Dept./Position Held	UnionLocal No.	Work Phone/Ext.

FINANCIAL RESPONSIBILITY

Name Mr. Ms. Mrs.	Relationship to Patient	Date of Birth	Sex	Social Security No. – –

Mailing Address	City	State	Zip Code

Alternate Address, if any	Email Address:

Home Phone	Work Phone/Ext.	Cell Phone	Pager

Best time and place to reach you	Employer (If self, name of business)	Dept./Position Held	UnionLocal No.	Work Phone/Ext.

INSURANCE & BILLING INFORMATION

Complete for each company	Primary Insurance	Secondary Insurance	Tertiary Insurance	Other Insurance
Insurance Company Name				
Insurance Address				
Policy or Group Number				
Subscriber ID Number				
Medicare Claim Number	– – –	– – –	– – –	– – –
Policy Holder's Name				
Policy Holder's Date of Birth				
Policy Holder's Soc. Sec. No.	– –	– –	– –	– –
Relationship to Patient				

AUTHORIZATION: I understand full payment for treatment received is my responsibility regardless of my insurance coverage. I hereby authorize the Clinic to release to my insurance company any information acquired in the course of examination or treatment. I further authorize my insurance company to pay directly to the Clinic any vision/medical/surgical benefits due me that have not been paid. This authorization shall expire upon written notice or one year from this date.

SIGNATURE DATE

UPDATE DATE

UPDATE DATE

UPDATE DATE

NOTICE: There is a finance charge imposed on the unpaid portion of your bill at the Clinic.

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