PATIENT INFORMATION (Age 18 and under) **CHRIS M. PETRAS, M.D.**

NAME OF PATIENT _____ (CALLED) _____
FIRST M. LAST

BIRTH DATE _____ AGE _____ SOCIAL SECURITY # _____
MO/DAY/YR

ADDRESS _____
STREET CITY STATE ZIP

NAME OF SCHOOL _____ GRADE_____

NAME OF PARENT OR GUARDIAN _____ RELATION _____

PARENT/GUARDIAN'S PREFFERED PHONE NUMBER _____ HOME NUMBER _____

NAME OF PERSON RESPONSIBLE FOR BILL (IF DIFFERENT FROM ABOVE) _____

ADDRESS/PHONE NUMBER OF PERSON RESPONSIBLE FOR BILL _____

NAME OF PEDIATRICIAN AND OR FAMILY DOCTOR _____

HAS ANY FAMILY MEMBER BEEN TREATED HERE? _____YES _____ NO NAME _____

REFERRED BY _____

PURPOSE OF VISIT _____

LIST ANY MEDICAL PROBLEMS _____

ALLERGIES TO MEDICATIONS: NO YES (LIST) _____

LIST CURRENT MEDICATIONS _____

NAME OF YOUR PHARMACY & PHONE _____

DO ANY FAMILY MEMBERS HAVE GLAUCOMA? ____ YES ___ NO

LIST ANY OTHER EYE DISEASES IN YOUR FAMILY_____

NOTE TO RESPONSIBLE PARTY:

PAYMENT FOR CO-PAYS AND NON-COVERED INSURANCE SERVICES IS DUE AT THE TIME OF SERVICE.

INSURANCE CLAIMS FOR SURGERY OR ACCIDENTS: Any claims filed on your behalf are to be paid within 45 days from the date of service. You will be billed for any claims your insurance carrier fails to pay within this 45 day period.

I have read the above and understand my financial obligation. I agree to make all necessary payments for services rendered. In addition, I understand that the patient (parent or guardian) is fully responsible for total payment of services including any amounts not covered by any health insurance or prepayment programs the responsible party may have. If the account is turned over for legal collections, the patient (parent or guardian) is also responsible for all cost of collection plus attorney fees.

DATE _____ X_____

SIGNED BY RESPONSIBLE PARTY